Supreme Court, U.S.
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No.

In the

Supreme Court of the United States

KENNETH FORD, DR.,

Petitioner,

v.

AETNA U.S. HEALTHCARE, INC., a Texas Corporation; THE METRAHEALTH CARE PLAN OF TEXAS, INC.; THE METRAHEALTH INSURANCE COMPANY; UNITED HEALTHCARE INSURANCE COMPANY, INC.; AETNA U.S. HEALTHCARE, INC., a Pennsylvania Corporation,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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109 pp

Questions Presented

The United States Court of Appeals, below, raised the issue of Article III standing *sua sponte*, with no notice to, nor any briefing or argument by, the parties and, purportedly on the facts but substantially misstating the record evidence regarding those facts, decided that issue against Dr. Ford. This raises the following questions:

1. Does the Court of Appeals' denial of Dr. Ford's appeal, based entirely on the *sua sponte*, no notice, purportedly fact-based finding on Article III standing, comply with constitutional due process?

2. What minimal procedural protections are required to satisfy the due process standard when Article III standing is addressed *sua sponte* on appeal?

3. What minimal evidentiary standard is required to comport with due process when Article III standing is addressed factually, but *sua sponte*, on appeal?

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Opinions Below

In 1996, Dr. Kenneth B. Ford sued three HMOs for false advertising under the Lanham Act. The respondents moved to dismiss. United States District Judge David Hittner initially denied those motions, including their challenge to Dr. Ford's prudential standing. Opinion of January 7, 1997, Appendix A. One party took an interlocutory appeal from part of that order. The United States Court of Appeals for the Fifth Circuit affirmed the District Court's Order and endorsed the basis for plaintiff's standing. *Ford v. Nylcare Health Plans of Gulf Coast, Inc.*, 141 F.3d 243 (5th Cir. 1998)(Appendix B).

Judge Hittner subsequently presided over a week-long class certification hearing. Approximately a year later, he denied certification. *Ford v. Nylcare Health Plans of Gulf Coast Inc.*, 190 F.R.D. 422 (S.D.Tex. 1999)(Appendix C).

Dr. Ford continued his individual action primarily for injunctive relief and preserved the certification issue and his claim for damages for appeal.

In 2001, after five years of discovery and pre-trial motions, Judge Hittner reversed his earlier ruling sustaining prudential standing and dismissed Dr. Ford's Lanham Act case expressly for lack of prudential standing. Opinion of April 10, 2001 (Appendix D).

Dr. Ford appealed the decisions of the trial court (a) denying class certification and (b) dismissing for lack of prudential standing. The Fifth Circuit affirmed the dismissal by a *sua sponte* ruling that Dr. Ford lacked Article III standing. The majority of the Court of Appeals panel ignored the District Court's rulings and all

the issues that had been briefed and argued on appeal. *Ford v. Nylcare Health Plans of Gulf Coast Inc.*, 301 F.3d 329 (5th Cir. 2002)(Appendix E). On August 27, 2002 the Fifth Circuit denied Dr. Ford's petitions for rehearing and rehearing en banc. Appendix F.

Grounds for Jurisdiction

Petitioner invokes this Court's jurisdiction under 28 U.S.C. § 1254(1). In accordance with Rule 13.4 of this Court, this petition is being filed within 90 days of the Fifth Circuit's denial of petitioner's motions for rehearing and for rehearing en banc on August 27, 2002. Appendix F. The District Court had subject matter jurisdiction under 28 U.S.C. § 1331. The Fifth Circuit had jurisdiction under 28 U.S.C. § 1291.

Constitutional and Statutory Provisions Involved

This petition arises from the protections of the Due Process Clause of the United States Constitution: "No person ... shall be deprived of life, liberty, or property, without due process of law ...." U.S. Const. amend. V.

Dr. Ford's claims are based on the Lanham Act:

> Any person who, on or in connection with any goods or services ... uses in commerce ... any false or misleading description of fact, or false or misleading representation of fact, which ... in commercial advertising or promotion, misrepresents the nature, characteristics, qualities, or geographic origin of his or her or another person's goods, services, or commercial activities, shall be liable in a civil action by any

> person who believes that he or she is or is likely to be damaged by such act.

15 U.S.C. § 1125(a)(1).

Statement of the Case

In 1996, Dr. Kenneth B. Ford sued the defendant HMOs alleging that their false advertising had enabled them to accumulate sufficient economic power to force Dr. Ford and similarly situated physicians into HMO management, where the physicians lost control over how they practice medicine and earned less money.

Dr. Ford's claim for injunctive relief against the HMOs' false advertisements is based on the Lanham Act, 15 U.S.C. § 1125(a)(1).[1]

District Judge David Hittner initially sustained Dr. Ford's prudential standing. Appendix A at 5-7. The Court of Appeals concurred in that conclusion in ruling on an interlocutory appeal: "As the district court correctly determined, Dr. Ford could maintain this action ...." The Court of Appeals explained:

> The competitive injuries alleged by Dr. Ford come in the form of patients and revenue lost as a result of consumers being misled into participating in the HMOs' health plan instead of going directly to the doctor of their choice and seeking reimbursement through the traditional health insurance route.

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[1] Dr. Ford reserves the right to bring claims for damages if the trial court's class certification ruling is reversed.

Ford v. Nylcare Health Plans of Gulf Coast Inc., 141 F.3d 243, 252 (5th Cir. 1998) (footnote omitted) (Appendix B).

Then, just shortly before trial and after years of discovery, Judge Hittner reversed his and the Court of Appeals' earlier rulings and held, incorrectly, that Dr. Ford lacked prudential standing. R.E.4 at 7-10.

Dr. Ford appealed that decision to the United States Court of Appeals for the Fifth Circuit. The Panel Majority, however, never reached the prudential standing issue. Instead, the Majority Opinion *sua sponte* raised and ruled on the issue of Article III standing, based *on purportedly factual grounds.*

This petition for writ of certiorari addresses primarily the Court of Appeals' due process failure in deciding Dr. Ford's case by raising and deciding a fact-issue without providing Dr. Ford any opportunity to present evidence or argument. However, it also raises whether the procedure and the evidentiary standard the Fifth Circuit applied in deciding constitutional standing *sua sponte* violates the Due Process Clause, this Court's precedents, and the procedures followed by the other circuits. Hampered as the Panel Majority was by having no briefs or argument on the issue it decided, the Panel Majority compounded its constitutional violation by basing its ruling on inaccurate descriptions of the record evidence.

Brief Statement of the Facts

A brief review of the underlying facts will give context to the due process violation inflicted on Dr. Ford when the Court of Appeals dismissed his action

without opportunity to present evidence or argument on the decisive issue.

Dr. Ford's action alleges that (a) the respondents advertise their HMO plans deceptively, which (b) enables the HMOs to attract large numbers of members, which (c) grants them market power sufficient to reduce doctors' incomes (d) by reducing the amount of care they authorize and by paying less for the care they do allow.

The defendants' own experts explain what they do – HMOs ration health care. Doc.240:2. They do it in two basic ways: (a) by directly reviewing and denying physician-recommended treatments and (b) by imposing compensation arrangements that inhibit doctors financially from providing care. To accomplish the first, the defendants employ what they call "utilization review," which Aetna euphemizes to "patient management," to reduce the amount of care provided. As was more fully described in Dr. Ford's principal brief below, the defendants review *ad hoc* physicians' medical decisions and approve or disapprove to reduce medical costs. For example, Aetna has four doctors in Dallas – a psychiatrist, an emergency room physician, an ear, nose and throat specialist, and a gastroenterologist – who determine whether prescribed treatments in a 15 state region are "medically necessary." These four doctors do not limit their decisions to patients in states where they are licensed or to their areas of speciality. Doc.240:3 at 145; 240:7 at 55-56, 104-11. When a decision of one of these four is "appealed" by a treating physician or patient, the appeal is decided by one of the same group of four. Doc.240:3 at 73-74; Doc.240:7.

The decisions that deny physician-recommended medical care are necessarily made without seeing or

examining the patients, without knowing the patients, and without having the patients' full medical histories. Doc.240:10; 240:7 at 104-05; 240:3 at 273; 240:5 at 112. The perspective of these HMO doctors is, of course, also very different from that of the treating physicians. As employees of the defendant insurers, the medical directors focus on the cost of the treating physician's recommendation. Doc.240:5 at 124-25, 150; 240:9 at 5. In brief, the medical directors substitute their cost-focused judgment for the treating physician's medical assessment, and do so with less information, responsibility, and expertise.

The defendant HMOs also inhibit medical care through financial disincentives (primarily risk sharing) that punish doctors economically for providing more care than the HMOs want. The HMOs are able to impose those inhibitions on medical doctors through their control of the patient market. They gain that control by false advertising.

The HMOs' inhibiting devices are not innocuous. Dr. Ford's medical expert, Dr. Arnold Relman (a physician and scholar of international renown), explained that these devices impair the doctor-patient relationship, intrinsically undermining the provision of medical care. *E.g.*, Doc.240:10.

The defendants' own experts concur. In their published works, they repeatedly note the growing evidence that managed care causes negative health outcomes, particularly for the sick and elderly. One principal defense expert, Dr. Harold Luft, has written: "Given financial incentives that do little to reward quality on the part of plans and providers, at least some unfavorable quality-of-care results are inevitable." Doc.240:12 at 2-14. Dr. Luft highlights recent studies on

"particularly vulnerable groups," which show that the elderly and chronically ill have demonstrably worse physical outcomes in HMOs than in fee for service arrangements. Doc.240:1 at 114-22, 163-64; Doc.240:18. The published works from the defendants' other main expert, Dr. Sidney Greenfield, register the same concerns:

> The zeal to contain the cost of medical care by reorganizing and selectively constraining specific elements of physicians' care, such as the length of time per patient, types of tests or procedures that will be reimbursed, etc., may place certain groups of patients, especially the elderly, the poor or less well educated, and minorities in particular risk for suboptimal technical and interpersonal care. Doc.240:19 at 1176.

In yet another study, Dr. Greenfield concluded: "Among patients of medical clinicians, ... those receiving care financed by prepayment were significantly less likely to have their depression detected or treated during the visit than were similar patients receiving fee-for-service care." Doc.240:20 at 3298.[2]

The HMOs advertise quite contrary to what they do. In fact the defendants have designed advertising themes that distance themselves from "managed care," claiming not to disrupt the physician-patient

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[2] The sick and elderly are particularly subject to adverse health outcomes from managed care because they incur the largest proportion of medical costs. Doc.240:5 at 53. As explained by Aetna's Chief Medical Director, elderly members are "far more subject to have clinical conditions that lend to those opportunities" to conduct utilization review. Doc.240:3 at 246-47.

relationship, not to decrease quality, and not to take control over medical decisions from patients and their doctors. For example, despite the controls they exercise over treating physicians based on cost, the defendant HMOs tout their plans in terms such as:

> "You have the comfort of knowing that all of your medical needs are managed by a primary care physician, someone who knows you and understands your specific needs, someone who will always work in your best interests...your primary care physician will be responsible for coordinating all of your medical needs." Doc.232:3 at iii.
>
> "At United HealthCare we believe that the people best qualified to make decisions about health care are patients and their doctors..." Doc.232:22.
>
> "Care Coordination keeps decision-making where it belongs - between doctors and their patients." Doc.232:23.

The advertising agency for the United defendants has stated that their primary "strategic challenge" was to: "Redefine managed care in a way that is believable" and to "further the notion that United HealthCare is not-managed care, indeed, counterpoised to it." Doc.240:25, 23 at 5. The Aetna defendants likewise "launched a communications program ... to counter the negative perceptions Aetna U.S. Healthcare faces as a managed care company." Doc.240:26 at 2.

Dr. Relman, has described how the defendants' managed care is far different from their advertising

claims, indeed how those claims are literally false. Doc.240:11 at 170.

Central to the standing issues is whether the defendants' false advertising affects physicians like Dr. Ford. The Fifth Circuit, without asking for any briefing, concluded it does not. There can be no dispute, however, about the basic economics, including especially that physicians like Dr. Ford make less money when the defendants increase the numbers of members in their HMO plans.

The defendant HMOs do not deny, indeed they trumpet, that greater membership in their HMO plans translates into lower incomes for doctors. Doc.231 at 28. Economic studies described by defendant HMOs' own experts confirm that managed care has had a ***competitive effect*** on traditional health providers. Doc.240:1 at 37. The competitive impact is amply demonstrated in Dr. Luft's articles: *The Competitive Effects of Health Maintenance Organizations* and *HMOs and the Medical Care Market.* Doc.240:55 and 56 at 86 ("HMOs compete directly with conventional insurance plans and indirectly with local hospitals and physicians."). Increased HMO membership also admittedly strengthens the market power of HMOs, allowing them to negotiate lower fees with doctors. Doc.240:47 at 47, 51-52; *see also* Doc.240:1 at 66-69; 240:47 at 47, 51-52. In short, the defendants' experts concede that HMOs compete, at least indirectly, with physicians. Doc.240:1 at 61; 240:55; 240:56.

Yet, despite the clear harm the HMOs' false advertising inflicts on Dr. Ford and his colleagues, the Court of Appeals concluded, without benefit of argument, that Dr. Ford could not establish the minimal requirements of constitutional standing to assert his

Lanham Act claim. That conclusion was wrong, but it was also virtually predetermined by the unconstitutional procedures and standards the Court of Appeals applied in addressing Article III standing *sua sponte.*

Reasons for Granting the Writ

This case has enormous public import. It addresses the heart of how managed care is altering the landscape of medical care in this Country. Managed care in concept is statutorily permitted. False advertising, however, the key to managed care's dominance, is statutorily proscribed. This Court has every interest in protecting the Lanham Act's salutary objectives, in seeing that its violations are appropriately redressed, and, in that context, ensuring that lower courts apply due process when they consider Article III standing, especially when they do so *sua sponte.*

Rather than address the issues that were briefed on summary judgment or on appeal, the Fifth Circuit raised the previously unmentioned issue of Article III standing *sua sponte.* Then, without providing Dr. Ford any opportunity to be heard or to marshal his facts on that issue, the court applied an overly stringent legal standard and decided the issue on incorrect renditions of the facts. The effect has been not only a denial of due process to Dr. Ford, but *de facto* license to the HMO respondents to swell their profits by violating the Lanham Act, at physicians' expense, with impunity.

Of course, the courts of appeals have the power, if not the duty, to raise jurisdictional issues *sua sponte,* but they do not have the power to raise those issues and summarily decide them without providing due process to the parties adversely affected. The power to raise

and decide issues *sua sponte* should be wielded with caution, so as not to prejudice parties' rights.

1. The lower courts are inconsistent and need this Court's guidance as to how to address Article III standing, when raised sua sponte, *in accord with due process.*

The Court of Appeals in this case addressed a district court's summary judgment that did not raise constitutional standing. Appendix E at 2-3. The Court of Appeals, though, denied the appeal based on its *sua sponte*, fact-based view that constitutional standing had not been proved.

At the district court level, Dr. Ford marshaled his evidence and responded to the issues actually raised in the defendants' motions for summary judgment. He did not, nor was he required to, anticipate any issue the Court of Appeals might raise *sua sponte*. There is no requirement that he have done so, and such a requirement would not be commonsensical. Dr. Ford was blindsided on appeal.

The lack of notice to Dr. Ford of the point the Court of Appeals found decisive was especially telling because that point, as addressed by the Court of Appeals, is fact-based. Dr. Ford could have presented evidence on the decisive point, but was denied the chance. That denial violates Dr. Ford's due process rights. Fundamental to the right to be heard, protected by the Due Process Clause, is the right to present evidence. L. Tribe, American Constitutional Law § 10-16, at 744 (2d ed. 1988).

If concerned about Article III standing, the Court of Appeals should have remanded the action to the

district court for it to hear Dr. Ford's evidence on that issue and address it in the first instance. That is what other circuit courts have done. Earlier this year, for instance, the Sixth Circuit raised *sua sponte*, but did not decide, the issue of Article III standing. *Sault Ste. Marie Tribe of Chippewa Indians v. United States*, 288 F.3d 910 (6th Cir. 2002). That court concluded that the standing issue "left us no alternative, [but to remand] the case to the district court for resolution of the question whether the Sault Tribe has standing to bring this suit." *Id.* at 913-14 (citation omitted). More recently, the Ninth Circuit also raised Article III standing *sua sponte*, but allowed the parties to brief the issue, and even then remanded the case "for the limited purposes of permitting (1) the appellants to amend their complaint; (2) the parties to supplement the record; and (3) the district court to determine in the first instance whether Article III standing exists in this case." *A.C.L.U. v. Heller*, 44 Fed. Appx. 767 (9th Cir. 2002).

The procedure applied here, on the other hand, or rather the lack of any procedure here, was simply to decide the whole appeal on an unannounced issue that was never briefed or argued. Not only that, but as demonstrated below, the denial of opportunity to be heard led the lower court to misread the record and Dr. Ford's proof.

In rare cases, it might be permissible for a court of appeals to decide constitutional standing *sua sponte*, but only when the issue is clear from the face of the pleadings. The Fifth Circuit followed that course in *Rivera v. Wyeth-Ayerst Laboratories*, 283 F.3d 315 (5th Cir. 2002). Constitutional standing in that case, however, turned entirely on the law, not the facts. The *Rivera* plaintiffs conceded they had no injury.

This case is different. The Court of Appeals here decided the standing issue on the facts: "Nothing in the record establishes the validity of either of the two links in this causal chain, and Ford must provide evidence of both if he is to establish the causation necessary for Article III standing." Appendix E at 4. Dr. Ford was deprived of due process by the Court of Appeals' failure to allow him the opportunity to marshal his evidence and argument on those points. This is especially so, since, as the Concurring Opinion notes, Article III standing is distinct from prudential standing, so none of the briefing before the Court of Appeals addressed the issue it decided. Appendix E at 4.

As demonstrated below, and contrary to what the Court of Appeals indicated about the facts, Dr. Ford has ample evidence to establish Article III standing. That the Court of Appeals got it wrong here is all the more evident since the same Court, through a different panel, had previously observed that Dr. Ford's standing was manifest from the allegations in his complaint. *See* Appendix B.

This action should be remanded to allow Dr. Ford to present his evidence and argument on Article III standing.

2. This Court should establish the proper evidentiary standard applicable to jurisdictional issues that are raised sua sponte.

In addition to depriving Dr. Ford of procedural due process, the Court of Appeals also erroneously imposed on him an overly stringent standard of proof. In the words of the Majority Opinion: "To meet the causation requirement, Ford would have to present

evidence ***affirmatively proving*** that the reduction in his income was a consequence of the HMO's restrictive policies ...." *Id.* (emphasis supplied).

That is too high a burden, at least at this stage of this proceeding.

This Court has indicated that a party's burden to establish Article III standing depends on the procedural posture of the action. *Lujan v. Defenders of Wildlife*, 112 S.Ct. 2130, 2136 (1991). Thus, "[a]t the pleading stage, general factual allegations of injury resulting from the defendant's conduct may suffice ...." *Id.* at 2137. At the summary judgment stage, a party has to raise a fact question, and "at the final stage, those facts (if controverted) must 'be supported adequately by the evidence adduced at trial.'" *Id.*

In keeping with this guidance, when constitutional standing is raised *sua sponte* on appeal, it should be assessed in the context of whether and at what stage the trial court addressed it. In this case, since constitutional standing was never raised in the trial court, it is the pleading standard that should apply. The Court of Appeals claimed to view it in the "summary judgment stage," Appendix E at 4, but, the standard it actually used, requiring affirmative proof, was the trial stage standard. Appendix E at 4. The summary judgment stage, at most, would only require evidence sufficient to raise a fact question regarding injury and causation.

Even if the Court of Appeals had applied the summary judgment standard, it would be error in this case because Article III standing was not raised by the defendants' motion for summary judgment. There was

nothing in the district court that required Dr. Ford even to raise a fact issue on Article III standing.

Applying a summary judgment standard in cases in which the issue of Article III standing is not raised by any motion for summary judgment would impose on plaintiffs the untenable burden of predicting and presenting evidence to meet any and all arguments that might ever arise in the future. Imposing that patently impossible burden violates due process. Plaintiffs cannot, at least not consistently with due process, be required to brief and present evidence on every possible but unmentioned jurisdictional question every time a summary judgment motion is filed. Plaintiffs should only be required to respond to the issues that are actually raised in the motion. *E.g.*, *Celotex Corp. v. Catrett*, 106 S.Ct. 2548 (1986). Any rule requiring more would not only violate due process, it would create havoc in the district courts as plaintiffs, to guard against *sua sponte* issues on appeal, tried to brief all manner of unidentified points.

Since constitutional standing was not raised by the defendants' summary judgment motions, Dr. Ford should only be required to ***allege***, not prove, facts sufficient to support Article III standing. As the Concurring Opinion below noted, and as the earlier Court of Appeals panel held, Dr. Ford has done that. Concurring Opinion at 4-5 ("Clearly, [Dr. Ford's] allegations satisfy the requirements of Article III.").

3. This Court should redress the constitutional injury inflicted on Dr. Ford by the Court of Appeals' applying an impossibly unfair procedure and an impermissible standard of proof.

Without question, the Court of Appeals' no notice procedure harmed Dr. Ford. On the evidentiary burden, the Court of Appeals set out two facts Dr. Ford had to prove to establish Article III standing: one, "that the reduction in his income was a consequence of the HMO's restrictive policies," and two, "that those policies in turn were established or at least made more onerous as a result of increased market power created by the acquisition of new customers through the defendants' allegedly deceptive ads." Appendix E at 4.

Despite the Court of Appeals' contrary characterizations of the record, there is record evidence entirely sufficient to prove both of those facts, but beyond that, those two facts are not the only available grounds for establishing constitutional standing.

(a) Dr. Ford has sufficient non-economic injury to support Article III standing.

The Court of Appeals assumed that actual injury means money. That is not true. Money may be all that concerns the defendant HMOs, but it is not the exclusive basis for Article III standing. Dr. Ford has certainly lost income at the defendant HMOs' hands, but that is not his only justiciable injury.

The non-monetary injury these HMOs inflict on doctors is palpable. As explained by Dr. Relman, the defendants' efforts to reduce the provision of medical care damages the doctor-patient relationship – Dr.

Ford's core commercial/professional relationship. Doc.240:11 at 280-284; 288-292. Dr. Relman's testimony on this point is compelling and beyond dispute. Notably, it is exactly the procedures the HMOs use to reduce costs (including physicians' incomes) that are destroying the goodwill embodied in the doctor-patient relationship.

The doctor-patient relationship, once the most respected of professional bonds, is being systematically undermined by the defendants' practices, including particularly their false advertising. That is actual injury sufficient to support standing. More to the point, given the Panel Majority's narrow reading of standing, Dr. Ford and other doctors are the ***only*** parties who can raise and redress this critical injury. The defendants are not adversely affecting the reputation and goodwill of other insurance carriers; they are impairing the historical doctor-patient relationship. Only physicians like Dr. Ford can redress that tear in the medical care thread of the fabric of our society.

This non-monetary injury more than suffices to establish Article III standing. As noted by this Court, even "an identifiable trifle is enough standing to fight out a question of principle; the trifle is the basis for standing and the principle supplies the motivation...." *United States v. Students Challenging Regulatory Agency Procedures*, 93 S.Ct. 2405, 2417 n.14 (1973).

Dr. Ford's complaints are not trifles – they dramatically impact the nature of his professional life, both in economic and intrinsic terms. Such injury is more than sufficient to support standing.

(b) Dr. Ford also has sufficient economic injury to support Article III standing.

Even if economic injury were the only injury recognized by the Constitution, the Court of Appeals still set the bar too high. Dr. Ford is not required to quantify an amount of economic injury in order to sustain standing. He need only show that "he personally has suffered some actual ***or threatened*** injury as a result of the putatively illegal conduct of the defendant." *Valley Forge Christian College v. Americans United for Separation of Church and State, Inc.*, 102 S.Ct. 752, 758 (1982)(emphasis added).

This is particularly true in this Lanham Act case, because the Lanham Act allows relief to "any person who believes that he or she is likely to be damaged by such act." 15 U.S.C. § 1125(a)(1)(B). Thus, there is standing if "there is a likelihood of injury to the plaintiff in terms of declining sales, loss of goodwill, etc." *Seven-Up Co. v. Coca-Cola Co.*, 86 F.3d 1379, 1383 n.3 (5th Cir. 1996)(citation omitted).

If Dr. Ford can prove a Lanham Act claim, indeed if he can make a fact question on the elements of a Lanham Act claim, he has established Article III standing, because the "actual or threatened injury required by Art. III may exist solely by virtue of 'statutes creating legal rights, the invasion of which creates standing.'" *Warth v. Seldin*, 95 S.Ct. 2197, 2206 (1975)(citation omitted). In other words, statutes can broaden the scope of injury that will support standing. *See id.; Lujan*, 112 S.Ct. at 2145-46. In this case, that means that Dr. Ford need only show a likelihood of injury, which, given the defendant HMOs' concession that their goal is to reduce payments to doctors, is manifest.

(c) Having deprived Dr. Ford of any opportunity to brief or argue Article III standing, the Court of Appeals erred in the fact findings on which it denied Dr. Ford's appeal.

Even if Dr. Ford could be required on appeal to marshal his evidence against an argument never before made, the Court of Appeals denied him even the opportunity to demonstrate what that record evidence contains. If he had been allowed to do so, Dr. Ford could have fulfilled even the Court of Appeals' overly stringent requirements.

The Court of Appeals' conclusion that "[n]othing in the record establishes the validity of either of the two links in this causal chain" is simply untrue. *See* Appendix E at 4. Dr. Ford provided evidence of both the fact and amount of the income he lost at the hands of the defendants in this case. Ford Exhibits 5 and 25, Class Certification Hearing.

Adding insult to injury, the Panel Majority tossed in two attributions to the District Court – that Dr. Ford's partners' incomes went up when Dr. Ford's went down and that Dr. Ford's hosting a televised fishing show "might" have caused Dr. Ford's income to fall – in order to conclude, incorrectly, that "[t]here is no evidence in the record to show that Ford's income has in fact declined any more than would be expected as a result of events completely unrelated to the HMO's' activities." Appendix E at 4.

First, the income of Dr. Ford's partners has gone down, not up, and has in fact gone down more dramatically than Dr. Ford's. *See* Dr. Ford's brief below at 59; Doc.240:54. At a minimum, this is a fact question.

As to Dr. Ford's ESPN fishing show, he testified quite clearly that he uses only vacation time to film the show, and it has not diminished the time devoted to his medical practice. R.19:82-83; Doc.240:54. He has consistently worked full time as a physician. *Id.*

Moreover, at the district court, neither of these points had anything to do with that court's analysis of prudential standing. These asides arose at the district court only in the context of Dr. Ford's adequacy as class representative, and even in that context, they failed. The district court found that Dr. Ford was an adequate class representative. These points are baseless insults. Neither of them supports any lack of standing. The Court of Appeals was wrong to say they did.

There is record evidence that Dr. Ford is paid less by the defendant HMOs for each and every procedure he performs for one of their members compared to his historical payments and to his current non-HMO patients. R.23:155-57; Doc.175:5, 25. Thus, regardless of how much Dr. Ford works, when he works on these HMOs' patients he is paid less than for his other patients. He is also paid less when any patient is persuaded by false advertising to switch from a less restrictive PPO plan to an HMO plan. Indeed it is the vast number of patients with whom these HMOs contract that forces Dr. Ford to submit to the lower HMO payment terms.

The defendant HMOs have never denied the connection between HMO membership and lower payments for medical treatment. No one else has denied it either until the Court of Appeals' ruling is this case. Despite what the Court of Appeals said, though, these HMOs not only reduce physicians' incomes, that is their core methodology. Even the defendants pegged

their standing argument on whether Dr. Ford competed against them, not on whether they reduced his income.

By not allowing briefing and argument the Court of Appeals not only misstated the facts, it missed the central point of what HMOs do, their very reason for being – reduce payments for the provision of health care in this Country and divert those sums into their own pockets.

Moreover, Dr. Ford is seeking an injunction, not just damages, and therefore he is not required to prove he has actually been injured, only that such injury is likely or threatened, and then only that there is a fact question on such likelihood. There is more than a threat or likelihood here. The defendants' stated goal is to reduce Dr. Ford's income from every surgery he is allowed to perform, and Dr. Ford has substantiated the impact on his own income. Under the Lanham Act, Dr. Ford is, therefore, entitled to challenge the defendants' method of achieving that goal.

Conclusion

The facts of this case are important – to Dr. Ford, to his colleagues, to the HMO defendants (to whom the relief sought in this case poses an enormous threat), and to the health care system in this Country. Now, given the opinion of the Court of Appeals below, this case is also important because of the procedures it establishes, which allow parties with significant and important claims, such as Dr. Ford, to be denied their day in court, after years of expensive battle, without an opportunity to be heard. In recognition of the importance of this case, both in substance and in procedural due process, Dr. Ford requests that this Court grant writ of certiorari.

Respectfully submitted,

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(any footnotes trail end of each documents)

(Appendix A)

CIVIL ACTION NO. 96-1564

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

DR. KENNETH FORD,
Plaintiff,

v.

NYLCARE HEALTH PLANS OF
THE GULF COAST, INC., et. al.,
Defendants

Entered January 7, 1997

ORDER

Pending before the Court are the Motion to Dismiss (Document #13) filed by Defendants Aetna Health Plans of Texas, Inc. and Aetna Life and Casualty Company, the Motion to Dismiss (Document #14) filed by Defendant Travelers Insurance Company, the Motion to Dismiss (Document #16) filed by Defendants MetraHealth Care Plan of Texas, Inc., The MetraHealth Insurance Company, and United HealthCare Corporation, the Motion to Dismiss (Document #18) filed by Defendant Metropolitan Life Insurance Ca, and the Motion to Compel Arbitration and Slay Litigation (Document #19) filed by Defendants NYLCare Health Plans of the Gulf Coast, Inc. and New York Life Insurance Company.fn1 Having considered the motions, the submissions on tile,

the applicable law, and the arguments of counsel at a hearing held on November 6, 1996, the Court determines that the motions should be granted in part and denied in part.

Plaintiff is an orthopedic surgeon. Defendants are managed health care organizations that sell group health insurance policies to employers. Defendants operate by contracting with certain physicians and then providing a higher level of coverage to patients who obtain health care from those physicians. If a patient wishes to obtain coverage for a visit to a specialist, Defendants require that the patient first obtain a referral from his or her primary care physician. Plaintiff has contracted with all of the defendants as a specialist.fn2

Plaintiff has brought suit for violations of the Texas Insurance Code, the 'Texas Deceptive Trade Practices Acts and the Lanham Act, and for tortious interference with business relations, negligence and negligent misrepresentation, fraud, breach of the duty of good faith and fair dealing, unjust enrichment, and for an accounting. Defendants have moved to dismiss all of these claims.

The Insurance Code Claim

Plaintiff claims that Defendants have engaged in deceptive acts toward their policyholders, insureds, and physicians, in violation of article 21.21 of the Texas Insurance Code.fn3 Defendants contend that Plaintiff lacks standing to assert a claim under article 21.21 because he is not an insured or an intended beneficiary of an insurance policy.

> Article 21.21, section 16(a) of the Texas Insurance Code provides:

> Any person who has sustained actual damages caused by another's engaging in an act or practice declared in Section 4 of this Article to be unfair methods of competition or unfair or deceptive acts or practices in the business of insurance or in any practice specifically enumerated in a subdivision of Section 17.46(b), Business & Commerce Code, as an unlawful deceptive trade practice may maintain an action against the person or persons engaging in such acts or practices.

Tex. Ins. Code Ann. art. 21.21, § 16(a). Although this language provides a cause of action to "any person," the right to sue under section 16(a) has been limited by Texas courts to persons in privity of contract with the insurer on an insurance policy or an intended beneficiary of an insurance policy. Texas Medical Ass'n v. Aetna Life Ins. Co., 80 F.3d 153, 159 (5th Cir. 1996); Shelton Ins. Agency v. St. Paul Mercury Ins. Co., 848 S.W.2d 739, 744 (Tex. App.—Corpus Christi 1993, writ denied) ("No authority exists to extend the meaning of the term 'person,' as found in art. 21.21, beyond one who was either an insured or an intended beneficiary of the policy.").

Plaintiff's complaint does not allege that Plaintiff is in privity with Defendants on an insurance policy or that Plaintiff is an intended beneficiary of an insurance policy. Therefore, Plaintiff may not assert a claim against Defendants under article 21.21 of the Texas Insurance Code. Texas Medical Ass'n, 80 F.3d at 160 (holding that doctors did not have standing under article 21.21 to bring suit against managed health care organization).

The Deceptive Trade Practices Act Claim

Plaintiff also claims that Defendants have engaged in deceptive and unconscionable acts in violation of the Texas Deceptive Trade Practices Act ("DTPA"). In order to bring a successful claim under the DTPA, a plaintiff must first show that he or she is a consumer. Hines v. Evergreen Cemetery Ass'n, 865 S.W.2d 266, 268 (Tex. App. Texarkana 1993, no writ). There are two requirements for consumer status under the DTPA: first, the claimant must have purchased goods or services, and, second, the goods or services must form the basis of the complaint. Americom Distrib. Corp. v. ACS Communications, Inc., 990 F.2d 223, 227 (5th Cr.), cert. denied, 510 U.S. 867 (1993). In addition, the goods or services purchased must be an objective of the transaction and not merely incidental to it. First State Bank v. Keilman, 851 S.W.2d 914, 929 (Tex. App.—— Austin 1993, writ denied).

In this case, Plaintiff argues that he is a consumer because he receives administrative services from Defendants in return for his willingness to take reduced payments for treating patients. Plaintiff contends that a "purchase" need not necessarily involve a cash payment but may encompass any transaction in which valuable consideration is given for the goods or services received. This Court agrees that a purchase need not involve a cash payment but finds nevertheless, that Plaintiff is not a consumer because the services on which he relies are not an objective of the transactions between Plaintiff and Defendants.

Plaintiff contracted with Defendants in order to increase the flow of patients seeking Plaintiff's services. It is this increase in the number of patients that was the objective of the transaction from Plaintiff's point of

view, and the increased patient load constitutes neither a good nor a service within the meaning of the DTPA. Although Defendants may provide Plaintiff with administrative and coordination services in connection with the new patients, these services are incidental to the transaction and do not serve to provide Plaintiff with consumer status. Therefore, because Plaintiff is not a consumer, he cannot assert a claim for violations of the DTPA.

The Lanham Act Claim

Plaintiff's Lanham Act claim is based on the manner in which Defendants advertise their services to consumers. Plaintiff claims that Defendants have made false statements in their advertising in violation of section 43(a) of the Lanham Act, codified at 15 U.S.C. § 1125(a). In response, Defendants contend, first, that Plaintiff has no standing to assert a Lanham Act claim because he is not a competitor of Defendants and, second, that the statements in Defendants' advertising of which Plaintiff complains are merely puffery and, as such, are not actionable under the Lanham Act.

In order to bring a claim for false advertising in violation of the Lanham Act, a plaintiff must allege a "discernibly competitive injury." Waits v. Frito-Lay, Inc., 978 F.3d 1093, 1109 (9th Cir. 1992), cert. denied. 506 U.S. 1080 (1993). The plaintiff need not be an actual competitor of the defendant, provided that the plaintiff has a reasonable interest to be protected against false advertising. Thorn v. Reliance Van Co., 736 F.2d 929, 933 (3d Cir. 1984); see also Seven-Up Co. v. Coca—Cola Co., 86 F.3d 1379, 1383 (5th Cir. 1996).

In this case, Defendants claim that Plaintiff cannot allege a discernibly competitive injury because doctors

and managed health care organizations provide different services to patients and have distinct roles within the health care system. Defendants further claim that the contractual relationship between Plaintiff and Defendants bars Plaintiff from claiming competitive status.

This Court is not persuaded by Defendants' arguments for two reasons. First, the fact that Plaintiff and Defendants have entered into a contractual relationship does not mean that Plaintiff cannot assert a reasonable interest to be protected against Defendants' false advertising. Thorn, 736 F.2d at 933 (finding that the plaintiff, who had entered into an investment contract with the defendants, had a reasonable interest to be protected against false advertising).

Second, Plaintiff's allegation that false advertising by Defendants draws patients away from Plaintiff constitutes an allegation of a discernibly competitive injury. Under the managed health care system currently in place in Texas, patients with health care coverage have a choice between signing up with a managed health care organization or going directly to the doctor of their choice and obtaining reimbursement through the traditional health insurance route. Plaintiff alleges that Defendants' advertising encourages patients who might otherwise have come directly to Plaintiff to sign up with Defendants' organizations. Plaintiff further alleges that once these patients sign up with a managed health care organization, they are discouraged from seeing specialists such as Plaintiff, and, if they are sent to Plaintiff, Plaintiff provides treatment at reduced rates in accordance with the managed health care contracts. This Court finds that the loss of patients and revenue resulting from a consumer's choice to sign up with a managed health care organization constitutes a

discernibly competitive injury and that Plaintiff therefore has standing to assert claim for false advertising in violation of the Lanham Act. See Waits, 978 F.2d at 1109 (providing as an example of a discernibly competitive injury the toss of customers to another party who has advertised falsely).fn4

Defendants' second argument in opposition to Plaintiff s Lanham Act claim is that the advertising of which Plaintiff complains constitutes mere puffery, which is not actionable under the Lanham Act. In order to maintain a claim for false advertising under the Lanham Act, a plaintiff must demonstrate that a commercial advertisement or promotion is either literally false or that the advertisement is likely to mislead and confuse consumers. Seven-Up Co 86 F.3d at 1390. Puffery is not actionable under the Lanham Act because it involves generalized assertions that are exaggerated to the point that consumers will not rely on them and therefore will not be misled by them. Cook, Perkiss & Liehe, Inc. v, Northern Cal. Collection Serv. Inc., 911 F.2d 242, 245-46 (9th Cir. 1990). When an advertising claim makes reference to an attribute that is specific and measurable, however, the claim does not constitute puffery and may be actionable! under the Lanham Act. Castrol Inc. v. Pennzoil Co., 987 F.2d 939, 946 (3d Cir. 1993).

In this case, Plaintiff alleges that Defendants have made false statements in their advertising relating to the quality of health care provided, the cost—effectiveness of Defendants' plans, and the level of benefits available. The statements relating to the quality of health care provided are typical of the kind of vague, generalized assertions that are unlikely to mislead consumers, and those statements therefore constitute puffery. The statements relating to cost—effectiveness and the level

of benefits, however, concern specific, measurable characteristics of the plans. Indeed, the cost—effectiveness of a health plan and the level of benefits provided by the plan are two of the main considerations of consumers in choosing a form of health coverage. Therefore, if Defendants have made false statements to the effect that their plans are the most cost—effective or provide the highest level of benefits, then those statements are likely to mislead consumers and do not constitute puffery.5 This Court declines to dismiss Plaintiff's Lanham Act claim on the ground that at least some of the statements alleged in the complaint do not constitute puffery and are therefore actionable under the Lanham Act.

Because Plaintiff's Lanham Act claim is not dismissed, it is necessary to address the motion to compel arbitration filed by Defendants NYLCare Health Plans of the Gulf Coast, Inc. ("NYLCare") and New York Life Insurance Company with regard to this claim. The motion to compel arbitration is based on the fact that the agreement entered into between Plaintiff and Defendant NYLCare contains an arbitration clause in which the parties agree to arbitrate "[a]ny controversy or claim arising out of or relating to this Agreement." The question here is whether Plaintiff's Lanham Act claim is a claim "arising out of or relating to" the agreement.

Plaintiff's Lanham Act claim is based on the manner in which Defendants advertise their services to consumers. Through this claim, Plaintiff is seeking to redress a competitive injury in the form of lost patients and revenue resulting from Defendants' advertising. Plaintiff's claim is not related to the agreement between Plaintiff and NYLCare because Plaintiff would suffer the same alleged competitive injury even in the absence of

the agreement. The injury is in the form of patients lost to managed health care plans, and that injury is suffered both by doctors who contract with the plans and by doctors who do not. Therefore, this Court finds that Plaintiff's Lanham Act claim does not arise out of or relate to the agreement between Plaintiff and NYLCare, and the motion to compel arbitration is denied with respect to this claim.

Tortious Interference with Business Relations

Plaintiff's claim for tortious interference with business relations is based on the allegation that Defendants have interfered with Plaintiff's relationships with patients by discouraging patients from seeing specialists such as Plaintiff. Defendants contend, first, that Plaintiff has not alleged the elements necessary to state such a claim and, second, that Plaintiff's claim is precluded by the fact that the Texas HMO Act expressly contemplates that primary care physicians will be responsible for making referrals to specialists.

Under Texas law, the elements of a claim for tortious interference with prospective contracts are:

> (1) a reasonable probability that the parties would have entered into a contractual relationship,
>
> (2) an intentional and malicious act by the defendant that prevented the relationship from occurring, with the purpose of harming the plaintiff,
>
> (3) the defendant lacked privilege or justification to do the act, and

> (4) actual harm or damage resulted from the defendant's interference.

Thrift v. Hubbard. 44 F.3d 348, 356-51 (5th Cir. 1995). In his complaint, Plaintiff alleges that Defendants have "constructed elaborate procedures and payment systems designed to discourage physicians from providing needed services and from referring patients to specialists who can provide needed care." Plaintiff's Original Complaint at ¶ 18. Plaintiff has thus alleged that Defendants' systems have interfered with a prospective relationship between Plaintiff and the patients and that these systems were designed to decrease the flow of business to Plaintiff. This Court finds that these allegations are sufficient to state a cause of action for tortious interference with prospective contracts.

Defendants also argue that, because the Texas HMO Act expressly contemplates that primary care physicians will be responsible for making referrals to specialists, Plaintiff cannot base a tortious interference claim on the fact that such a referral system exists. The Texas HMO Act defines a primary care physician as "[a] physician or provider who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care." Tex. Admin. Code tit. 28, § 11.2. The Act does not say, however, that managed health care organizations may discourage primary care physicians from making referrals to specialists. Therefore, Defendants' argument that the conduct of which Plaintiff complains is countenanced by the Act must fail.

Finally, the motion to compel arbitration tiled by Defendants NYLCare Health Plans of the Gulf Coast, Inc. and New York Life Insurance Company is denied with respect to this claim for the same reasons provided in

connection with Plaintiff's Lanham Act claim. Plaintiff's tortious interference claim would exist even in the absence of an agreement between Plaintiff and NYLCare, as the injury alleged is in the form of business lost through a patient's decision to sign up with a managed health care organization. Therefore, Plaintiff's tortious interference claim does not arise out of or relate to the agreement between Plaintiff and NYLCare.

Negligence and Negligent Misrepresentation

Plaintiff's negligence and negligent misrepresentation claims are based on Defendants' alleged failure to perform on promises made by Defendants to Plaintiff. Defendants contend that these claims cannot properly sound in tort because they are nothing more than disguised breach of contract claims.

If a defendant's conduct gives rise to liability only because it breaches an agreement between the plaintiff and the defendant, then the plaintiff's claim ordinarily sounds only in contract and not in tort. Southwestern Bell Tel. Co. v. DeLanney 809 S.W.2d 493, 494 (Tex. 1991). Determining whether a claim sounds in tort or only in contract involves a two—step inquiry: the court should first determine whether the defendant's conduct violates duties imposed by law, independent of those imposed by the contract, and then determine whether the alleged injury is more than just the economic loss to the subject of the contract. Heller Fin. Inc. v. Grammco Computer Sales, Inc., 71 F.3d 518, 528 (5th Cir. 1996).

In this case, Plaintiff's negligence and negligent misrepresentation claims are based solely on allegations that Defendants have failed to live up to the promises made in connection with the agreements between Plaintiff and Defendants. Plaintiff has pointed to no

duties imposed by law, as opposed to duties imposed by the contracts, that have been violated by Defendants' failure to keep their promises. Plaintiff cannot maintain claims in tort for Defendants' violations of duties imposed only by the contracts, and Plaintiffs negligence and negligent misrepresentation claims must therefore be dismissed.

Fraud

Plaintiff's fraud claim does not specify the conduct on the part of Defendants on which the claim relies, but merely states: "The defendants' conduct constitutes fraud." Defendants contend that Plaintiffs fraud claim violates Rule 9(b) of the Federal Rules of Civil Procedure.

Rule 9(b) provides: "In all averments of fraud or mistake the circumstances constituting fraud or mistake shall be stated with particularity." Fed. R. Civ. P. 9(b). These "circumstances" that must be pleaded in detail include "the who, what, when, where, and how: the first paragraph of any newspaper story." DiLeo v. Ernst & Young, 901 F.2d 624 626 (7th Cir.), cert. denied, 498 U.S. 941 (1990); see also Shushany v. Allwaste, Inc., 992 F.2d 517, 521 (5th Cir. 1993) (requiring allegations of the time, place, and contents of false representations, as well as the identity and motive of the person making the misrepresentations).

In this case, Plaintiff claims that Defendants have made fraudulent misrepresentations to Plaintiff independent of the promises made in connection with the contracts between Plaintiff and Defendants. Plaintiff's complaint, however, does not set forth any of the details surrounding these misrepresentations and completely fails to identify the "who, what, when, where, and how," as required by Rule 9(b). Plaintiff's

fraud claim is therefore dismissed for failure to comply with Rule 9(b). If, however, Plaintiff is able to assert particularized allegations of fraud that violate duties independent of those imposed by the contract, Plaintiff is granted leave to amend his complaint to make those allegations. See Summer v. Land & Leisure, Inc., 664 F.2d 965, 971 (5th Cir. 1981) (indicating that dismissal for failure to comply with Rule 9(b) is almost always with leave to amend), cert. denied, 458 U.S. 1106 (1982).

Breach of the Duty of Good Faith and Fair Dealing

Plaintiff claims that Defendants' control over certain information and Defendants' superior bargaining position create a duty of good faith and fair dealing toward Plaintiff, and that Defendants have breached that duty. Defendants contend that they do not owe a duty of good faith and fair dealing to Plaintiff.

Under Texas law, a duty of good faith and fair dealing arises only in cases in which there is a "special relationship" between the parties, such as the relationships between insurer and insured, principal and agent, joint venturers, and partners. Cole v. Hall, 864 S.W.2d 563, 568 (Tex. App-Dallas 1993, writ dism'd w.o.j.). Such a special relationship has been found to exist between a dental care provider and a managed health care organization with which the provider has contracted. See Sanus/N.Y. Life Health Plan, Inc. v. Dube-Seybold-Sutherland Management. Inc., 837 S.W.2d 191, 199 (Tex. App.-Houston [1st Dist.] 1992, no writ). In Sanus, the court based its finding of a special relationship on the fact that the dental provider was totally dependent on information that was within the control of the managed health care organization in order to determine which patients to treat and how much it was owed in "capitation" payments. fn6 See id.

Defendants attempt to distinguish this case on the ground that Plaintiff is not paid on a capitation basis and so does not rely on information that is within Defendants' exclusive control.

Plaintiff alleges that Defendants have total control over information on which they base the amount of their payments to physicians. Although Plaintiff does not allege that he is paid on a capitation basis, he does allege the same dependence on information within the control of the managed health care organizations that was present in Sanus. Plaintiff's allegations are therefore sufficient to survive a motion to dismiss with respect to his claim for breach of the duty of good faith and fair dealing.

Finally, Plaintiff has conceded that his claim for breach of the duty of good faith and fair dealing relates to his contracts with Defendants. Therefore the motion to compel arbitration filed by Defendants NYLCare Health Plans of the Gulf Coast, Inc. and New York Life Insurance Company is granted with respect to this claim.

Unjust Enrichment

Plaintiff claims that he is entitled to recover under the theory of unjust enrichment because Defendants' profits have been wrongfully acquired The elements of an unjust enrichment, or quantum meruit, claim are:

> 1) valuable services were rendered or materials furnished; 2) for the person sought to be charged; 3)which services and materials were accepted by the person sought to be charged, used and enjoyed by him; 4) under such circumstances as

> reasonably notified the person sought to be charged that the plaintiff in performing such services was expecting to be paid by the person sought to be charged.

Bashara v. Baptist Memorial Hospital Sys., 685 S.W.2d 307, 310 (Tex. 1985) (quoting City of Ingleside v. Stewart, 554 S.W.2d 939, 943 (Tex. Civ. App.——Corpus Christi 1977, writ ref'd n.r.e.))

Plaintiff has not alleged that he provided any services or materials to Defendants that were accepted by Defendants under circumstances that would have notified Defendants that Plaintiff expected to be paid for those services or materials. Therefore, Plaintiff's unjust enrichment claim must be dismissed.

Accounting

Plaintiff claims that he is entitled to an accounting of the funds in "incentive accounts" maintained by some of the defendants. An equitable accounting is proper when the facts and accounts presented are so complex that adequate relief may not be obtained at law. Hutchings v. Chevron U.S.A.. Inc., 862 S.W.2d 752, 762 (Tex. App.—— El Paso 1993, writ denied). Plaintiff has not alleged that standard discovery procedures are inadequate to provide him with the information he seeks, and his claim for an accounting is therefore dismissed. See id. I

Based on the foregoing, the Court

ORDERS that the Motion to Dismiss (Document #13), the Motion to Dismiss (Document #14), the Motion to Dismiss (Document #16), and the Motion to Dismiss (Document #18) are GRANTED with respect to Plaintiff's Insurance Code claim, DTPA claim, and

claims for negligence and negligent misrepresentation, fraud, unjust enrichment, and an accounting.

IT IS FURTHER ORDERED that the Motion to Compel Arbitration and Stay Litigation (Document #19) is GRANTED with respect to Plaintiff's claim for breach of the duty of good faith and fair dealing.

IT IS FURTHER ORDERED that Plaintiff is GRANTED leave to amend his complaint to assert particularized allegations of fraud if such fraud violated duties independent of those imposed by the contract.

All other relict not specifically granted herein is DENIED.

SIGNED at Houston, Texas, on this 3rd day of January, 1997.

DAVID HITTNER
United States District Judge

Footnotes

fn1 Defendants NYLCare Health Plans of the Gulf Coast, inc. and New York Life Insurance Company have joined in the motions to dismiss filed by the other defendants but do not waive their right to pursue their motion to compel arbitration.

fn2 Plaintiff is also seeking class certification of a class of all specialists who have contracted with any of the defendants. The Court has not yet ruled on Plaintiff's request for class certification.

fn3 Article 21.21 of the Texas Insurance Code prohibits any trade practice that is "an unfair method of

competition or an unfair or deceptive act or practice in the business of insurance." Tex. Ins. Code Ann. art. 21.21, § 3.

fn4 Defendants rely on the case of Halicki United Artists Communications, Inc., 812 F.2d 1213 (9th Cir. 1987), in their effort to demonstrate that Plaintiff cannot allege a competitive injury. In Halicki, the court found that a movie producer could not assert a false advertising claim against several movie theater companies who had advertised the wrong rating for his movie. id. at 1213—14. The court recognized, however, that the producer might have been able to maintain his claim if he had alleged that the theater companies benefited by decreasing the box office attraction of his movie, See id. at 1214. Such a situation would be similar to the present case, in which Defendants benefit from encouraging patients to sign up with them rather than go directly to the doctors.

fn5 The case of Gordon & Breach Science Publishers S.A. v. American Institute of Physics, 905 F. Supp. 169, 182 (S.D.N.Y. .1995), in which statements regarding cost-effectiveness were found to constitute puffery, is distinguishable from the present case. In that case, the challenged advertisements were for scientific journals. The statements in that case were less likely to mislead consumers than those involved in the present case because cost—effectiveness is less likely to be one of the primary considerations of consumers who are selecting a scientific journal.

fn6 Capitation payments are payments based on an adjusted head count of health plan members assigned to a particular provider's care. Sanus, 837 S.W.2d at 193.

(Appendix B)

No. 97-20109

UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

KENNETH FORD, Dr., Plaintiff-Appellee,

versus

NYLCARE HEALTH PLANS OF THE GULF COAST, INC., ET AL., Defendants, NYLCARE HEALTH PLANS OF THE GULF COAST INC.; NEW YORK LIFE INSURANCE COMPANY, Defendants-Appellants.

May 26, 1998, Decided

COUNSEL:
For KENNETH FORD, Dr, Plaintiff - Appellee: Mark W Maney, Wynne & Maney, Kenneth R Wynne, Houston, TX.

For NYLCARE HEALTH PLANS OF THE GULF COAST INC, NEW YORK LIFE INSURANCE COMPANY, Defendants - Appellants: Neal Stuart Manne, J Hoke Peacock, III, Susman Godfrey, Houston, TX.

JUDGES:
Before JOLLY, WIENER, and STEWART, Circuit Judges.

OPINIONBY:
E. GRADY JOLLY

OPINION:

E. GRADY JOLLY, Circuit Judge:

In this appeal, we consider whether an agreement providing for the arbitration of all disputes "arising out of or relating to" the agreement may be invoked to compel arbitration of a cause of action that does not depend as a legal matter on the agreement. The appellants, NYLCare Health Plans of the Gulf Coast, Inc., and its parent corporation, New York Life Insurance Co., are federally qualified health maintenance organizations ("the HMOs"). n1 Dr. Kenneth Ford, like many other physician-specialists, entered into an agreement with the HMOs to provide certain medical services to beneficiaries covered under their health plans. Dissatisfied with the way the HMOs were managing physicians and health care, and with the accuracy of the HMOs' advertising to consumers, Dr. Ford brought this action against the HMOs for, inter alia, false advertising in violation of the Lanham Act, 15 U.S.C. §1125(a). Based on the arbitration clause in their agreement with Dr. Ford, the HMOs petitioned the district court to compel arbitration of the lawsuit under the Texas General Arbitration Act ("TGAA") and the Federal Arbitration Act ("FAA"). The district court denied the petition with respect to the false advertising claim, and the HMOs appeal. We conclude that, under the TGAA, the arbitration clause in the agreement between Dr. Ford and the HMOs does not reach the false advertising claim. We therefore affirm.

I

A

The facts of this case revolve around the agreement between Dr. Ford and the HMOs. Dr. Ford, an orthopedic surgeon, signed the agreement in December 1986. The agreement continues in effect from year to year until either party elects to terminate it. Neither Dr. Ford nor the HMOs have done so, and it remains in effect to this day. Dr. Ford entered into this agreement

with the HMOs to provide medical services to those beneficiaries covered by the HMOs' health plan who require the attention of a specialist. In return for these services, the HMOs agreed to compensate Dr. Ford according to a rate schedule maintained by the HMOs. The agreement forbids Dr. Ford from seeking any payment for his services except from the HMOs and, then, subject to their payment procedures and schedules.

As a specialist under the agreement, Dr. Ford is permitted to treat a beneficiary covered by the HMOs' plan only upon proper referral by another physician who has contracted with the HMOs to provide primary care services to that beneficiary. When a specialist like Dr. Ford believes a beneficiary requires the attention of another specialist, referral is permissible only in cases involving "medical emergencies," a term defined by the agreement as the "sudden and unexpected onset of a condition of sufficient seriousness that failure to receive immediate medical or surgical care would jeopardize the life or seriously impair the health of the patient." This requirement may be waived only upon approval by HMO personnel. Even then, the referred specialist must also have contracted with the HMOs and have the referral approved by the primary care physician. "Incentive Withhold Pools" created by the agreement provide that 25% of all payments to primary care physicians and specialists are withheld to pay for medical cost overruns. The agreement likewise establishes a "Referral Services Pool," from which referral costs are paid. Annual surpluses in the referral pool are returned to physicians, while annual deficiencies are compensated by drawing funds from the incentive withhold pools.

The agreement also contains an arbitration clause. It states, in relevant part:

> Any controversy or claim arising out of or relating to this Agreement, or the breach thereof shall be settled by arbitration in accordance with the Texas General Arbitration Act, and judgment upon the award rendered may be enforced in any Court of the State of Texas having jurisdiction thereof . . . . The arbitration proceeding shall be conducted in Harris County, Texas. . . .

The front page of the agreement further states, underlined and in bold type: "NOTICE: THIS AGREEMENT IS SUBJECT TO ARBITRATION UNDER THE TEXAS GENERAL ARBITRATION ACT." The scope of the arbitration clause is the focus of this litigation.

B

On May 15, 1996, Dr. Ford brought this action against the HMOs n2 based generally on his dissatisfaction with the way the HMOs administered physicians in their provision of health care services and the way the HMOs advertised the benefits of their plan to consumers. Dr. Ford claimed that these practices constituted false advertising under section 1125(a) of the Lanham Act and violated the Texas Insurance Code and Texas Deceptive Trade Practices Act ("TDTPA"). In support of these claims, he alleged that the HMOs make tall promises to consumers about the quality of health care their plan is designed to provide, but that the plan actually results in a reduced quality of care because of medical decision-making by relatively unqualified individuals, burdensome internal procedures, and incentive programs designed to minimize medical costs at the expense of needed health care measures. Rather than using premiums to provide effective health care as promised, Dr. Ford alleged, the HMOs divert needed

funds to fill "overflowing corporate coffers" and to pay "bloated executive salaries." Dr. Ford also alleged claims for tortious interference with business relations, negligence, negligent misrepresentation, fraud, breach of good faith and fair dealing, unjust enrichment, and a right to an accounting. Because the HMOs had entered agreements similar to Dr. Ford's with many other specialist-physicians, n3 Dr. Ford sought to bring these claims in a class action on behalf of himself and all other specialist-physicians who had contracted with the HMOs under a managed care plan.

The HMOs filed a motion to dismiss Dr. Ford's claims and a petition to compel arbitration. On January 3, 1997, the court dismissed the claims based on the Texas Insurance Code, the TDTPA, negligence, negligent misrepresentation, unjust enrichment, and the right to an accounting. The court then ordered arbitration of the claim for breach of the duty of good faith and fair dealing. It refused, however, to compel arbitration of the false advertising and tortious interference claims. The court reasoned that these claims would exist in the absence of the agreement between Dr. Ford and the HMOs and, therefore, did not arise out of or relate to that agreement. The court did not specify whether federal or state law governed its analysis. The HMOs appeal this order. They contend that although the district court basically employed the correct test to determine whether those claims were arbitrable, it applied the test incorrectly. Based on the allegations in Dr. Ford's complaint, the HMOs argue, the false advertising and tortious interference claims are related to the agreement between the parties and thus come within the scope of the arbitration clause.

Dr. Ford, in an effort to better limit the case to an easily definable class action, has since agreed to send the tortious interference claim to arbitration. n4 Thus,

we consider only the arbitrability of the false advertising claim in this appeal. "Resolving this dispute is a matter of contract interpretation and therefore is subject to de novo review by this court." Neal v. Hardee's Food Sys., Inc., 918 F.2d 34, 37 (5th Cir. 1990).

II

Ordinarily, "the first task of a court asked to compel arbitration of a dispute is to determine whether the parties agreed to arbitrate that dispute." Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc., 473 U.S. 614, 626, 87 L. Ed. 2d 444, 105 S. Ct. 3346 (1985). And, ordinarily, "the court is to make this determination by applying the 'federal substantive law of arbitrability, applicable to any arbitration agreement within the coverage of the FAA.'" Id. (citations omitted). The arbitration clause in the agreement between Ford and the HMOs in this case, however, states that controversies would be subject to arbitration in accordance with the Texas General Arbitration Act. This provision is significant evidence that the parties intended the scope of the clause to be determined according to Texas law. Citing Atlantic Aviation, Inc. v. EBM Group, Inc., 11 F.3d 1276 (5th Cir. 1994), the HMOs argue that such references to Texas law are irrelevant because, even if the parties had chosen Texas law to govern arbitration, the FAA preempts any otherwise applicable state law if the agreement involves commerce. n5

A

We will consider as a threshold matter, therefore, whether parties may designate state law to govern the scope of an arbitration clause in an agreement otherwise covered by the FAA. Clearly, they can. The federal policy underlying the FAA "is simply to ensure the enforceability, according to their terms, of private

agreements to arbitrate." Volt Information Sys., Inc. v. Board of Trustees of the Leland Stanford Junior Univ., 489 U.S. 468, 476, 103 L. Ed. 2d 488, 109 S. Ct. 1248 (1989) (emphasis added). Indeed, the FAA was specifically designed to place arbitration agreements "'upon the same footing as other contracts.'" Scherk v. Alberto-Culver Co., 417 U.S. 506, 510-11, 41 L. Ed. 2d 270, 94 S. Ct. 2449 (1974) (quoting H.R. Rep. No. 96, 68th Cong., 1st Sess., 1, 2 (1924)). And, "as with any other contract, the parties' intentions control" the ultimate interpretation of an arbitration clause. Mitsubishi, 473 U.S. at 626. For "arbitration under the [FAA] is a matter of consent, not coercion, and parties are generally free to structure their arbitration agreements as they see fit." Volt, 489 U.S. at 479; see also Drake Bakeries, Inc. v. Local 50, Am. Bakery & Confectionery Workers Int'l, AFL-CIO, 370 U.S. 254, 256, 8 L. Ed. 2d 474, 82 S. Ct. 1346 (1962) ("the issue of arbitrability is a question for the courts and is to be determined by the contract entered into by the parties"); Baravati v. Josephthal, Lyon & Ross, Inc., 28 F.3d 704, 709 (7th Cir. 1994) (Posner, C.J.) ("short of authorizing trial by battle or ordeal or, more doubtfully, by a panel of three monkeys, . . . parties are as free to specify idiosyncratic terms of arbitration as they are to specify any other terms in their contract").

Applying these principles, the Supreme Court has recognized that parties may use choice-of-law provisions to designate state law to provide the procedural rules under which arbitration will be conducted. See Volt, 489 U.S. at 476. In Volt, the parties had entered into an agreement with a general choice-of-law clause providing that the agreement be governed by the law of the place where the subject of the agreement was located, which in that case was California. See id. at 470. The issue was whether a procedural rule in the California Arbitration Act, not available under the FAA,

should be interpreted to apply to the arbitration agreement. The Court held that it should, stating:

> Just as [the parties] may limit by contract the issues which they will arbitrate, . . . so too may they specify the rules under which that arbitration will be conducted. Where, as here, the parties have agreed to abide by state rules of arbitration, enforcing those rules according to the terms of the agreement is fully consistent with the goals of the FAA, even if the result is that arbitration is stayed where the [FAA] would otherwise permit it to go forward.

Id. at 479. As the above-quoted passage demonstrates, the Court expressly analogized the parties' freedom to limit contractually the scope of the arbitration clause with their freedom to select the rules under which arbitration will be conducted. It follows, then, that if the parties may select the rules of arbitration through the use of choice-of-law provisions, so too may they specify the law governing interpretation of the scope of the arbitration clause. Indeed, we think that to disregard the parties' choice of law in this respect "would be quite inimical to the FAA's primary purpose of ensuring that private agreements to arbitrate are enforced according to their terms." Id. n6

Consequently, the issue we must address here is whether the parties intended state law to govern the scope of their agreement to arbitrate. If the agreement between Dr. Ford and the HMOs demonstrates their intent to have the scope of the arbitration clause determined by Texas law, we must respect that choice.

Only by rigorously enforcing arbitration agreements according to their terms, do we "give effect to the contractual rights and expectations of the parties, without doing violence to the policies behind the FAA." Volt, 489 U.S. 468 at 479, 109 S. Ct. 1248, 103 L. Ed. 2d 488.

B

We thus consider the agreement between Dr. Ford and the HMOs to determine whether the parties contemplated Texas law to govern the scope of the arbitration clause. We begin with the arbitration clause itself, focusing on whether any choice-of-law provision in the clause is relevant to the issue at hand. See Mastrobuono v. Shearson Lehman Hutton, Inc., 514 U.S. 52, 64, 131 L. Ed. 2d 76, 115 S. Ct. 1212 (1995) (holding that choice-of-law provision in arbitration clause covered arbitration, while general choice-of-law clause in contract covered the other rights and duties of the parties). The clause in this case states that arbitration of any claim must be settled "in accordance with the Texas General Arbitration Act." On its face, this provision would seem to designate the TGAA as the law governing all aspects of arbitration under the agreement. Although the HMOs proposed at oral argument that the provision could be read to make the TGAA applicable only to the procedural aspects of arbitration, they conceded that nothing in the arbitration clause supported such limited application. Nor does anything in the TGAA suggest that it would not apply to issues such as the scope of the arbitration clause. It consists of more than procedural rules. Like the FAA, the TGAA contains substantive provisions governing both the validity and enforceability of arbitration agreements. See, e.g., Tex. Civ. Prac. & Rem. §171.001. The HMOs simply furnish no reason to believe that Texas law and the TGAA apply to anything

less than every aspect of arbitration under their agreement with Dr. Ford.

Nothing in the remainder of the arbitration clause or the body of the agreement indicates otherwise. The arbitration clause goes on to provide that any arbitration proceedings under the agreement "shall be conducted in Harris County, Texas." Judgment upon any arbitration award may be enforced only in a "Court of the State of Texas having jurisdiction thereof." Disagreements over arbitrators are to be resolved by "any judge of any Court of the State of Texas, having jurisdiction and located in Harris County." As for the main body of the agreement, the first page announces in bold type: "NOTICE: THIS AGREEMENT IS SUBJECT TO ARBITRATION UNDER THE TEXAS GENERAL ARBITRATION ACT." The rest of the agreement contains only general references to other applicable laws. The first page notes that physicians must provide or arrange for basic health care services as required by what the agreement defines as the "HMO Laws": the Health Maintenance Organization Act of 1973, 42 U.S.C. § §300e, et seq., and the Texas Health Maintenance Organization Act, Tex. Ins. Code ch. 20A. Finally, in a general choice-of-law clause of sorts, the agreement provides that it "shall be governed in all respects by the HMO Laws and any other applicable laws or regulations."

Examining the agreement as a whole, we are persuaded that the parties intended Texas law and the TGAA to govern the scope of the arbitration clause. The clause itself specifies that arbitration is to be governed by the TGAA. Other provisions in the arbitration clause lean heavily in favor of applying Texas law to determine the arbitrability of disputes under the agreement. Nothing else in the agreement suggests that the parties intended federal law or the FAA to apply. Indeed, the only provision in the entire agreement possibly making a

law applicable to arbitration other than Texas law can, at best, be characterized as an extremely general choice-of-law clause. And it, in relevant part, simply makes the unremarkable observation that the agreement generally is governed by all applicable laws or regulations.

Finally, to the extent that the general choice-of-law clause could conceivably be read to create an ambiguity, we construe ambiguous contract language against the party who drafted it. See Mastrobuono, 514 U.S. at 62 (applying the common law rule to interpretation of arbitration clauses). If the HMOs drafted an ambiguous document, they cannot now claim the benefit of the doubt. "The reason for this rule is to protect the party who did not choose the language from an unintended or unfair result." Id. at 63. As in Mastrobuono, "that rationale is well-suited to the facts of this case." Id. Thus, we hold that Texas law and the TGAA govern the scope of the arbitration clause in this case.

III

Having determined that the arbitrability of Dr. Ford's false advertising claim is governed by Texas law and the TGAA, we turn now to interpret the scope of the arbitration clause under Texas law. Texas courts favor arbitration. Monday v. Cox, 881 S.W.2d 381, 384 (Tex. App. 1994). Whether a claim falls within the scope of an arbitration agreement under Texas law depends on the factual allegations of the complaint instead of the legal causes of action asserted. See X.L. Ins. Co., Inc. v. Hartford Accident & Indem. Co., 918 S.W.2d 687, 689 (Tex. App. 1996, writ requested). A tort claim, like Dr. Ford's false advertising claim, see Chevron Chem. Co. v. Voluntary Purchasing Groups, Inc., 659 F.2d 695, 700-01 (5th Cir. Unit A Oct. 1981) (false advertising claims under Lanham Act are based on the common law tort), is arbitrable if it is "so interwoven with the contract that it could not stand alone, but is not arbitrable if it is

completely independent of the contract and could be maintained without reference to a contract." X.L. Insurance Co., 918 S.W.2d at 689; accord Valero Energy Corp. v. Wagner & Brown, 777 S.W.2d 564, 566 (Tex. App. 1989, writ denied).

A

The HMOs contend that the allegations in the complaint supporting Dr. Ford's false advertising claim are interwoven with the agreement sufficiently to make the claim arbitrable, even under Texas law.n7 In particular, the HMOs cite Dr. Ford's allegations that the HMOs promise consumers "cost effective and high quality health care" but instead provide a "labyrinthine system that ultimately denies effective health care" by constructing elaborate payment systems designed to discourage physicians from providing necessary care and by rejecting physician-recommended procedures. The HMOs further cite Dr. Ford's allegations of a reduced quality of care resulting from the referral systems and financial incentive pools established in the agreement. The HMOs argue that although Dr. Ford certainly could have stated a false advertising claim without referencing the agreement in the factual allegations of his complaint, he did not. Thus, they conclude, his false advertising claim cannot exist without the agreement.

The HMOs' argument, we think, fundamentally misconceives the test for whether a tort claim is sufficiently related to the agreement to be arbitrable. To be sure, the test focuses on the factual allegations in the complaint instead of the legal labels attached to the causes of action. See X.L. Insurance Co., 918 S.W.2d at 689. It does so, however, not to identify whether the facts in support of the action will implicate the agreement as an item of evidence, but to uncover whether an action formally labeled a tort is in essence a

breach of contract claim or based on a breach of contract. See, e.g., Valero Energy Corp., 777 S.W.2d at 566 ("[The plaintiff] here is asserting a tort claim that is directly related to its rights under the contract. It could have just as easily alleged a breach of contract action under the fact situation presented."). Because a breach of duty owed under a contract may involve tortious conduct, a dispute arising out of a contractual relationship may give rise to both breach of contract and tort claims at the same time. See id. Basing the arbitrability of an action merely on the legal label attached to it would allow artful pleading to dodge arbitration of a dispute otherwise "arising out of or relating to" (or legally dependent on) the underlying contract. To avoid this contrivance, courts look at the facts giving rise to the action and to whether the action "could be maintained without reference to the contract," id. (emphasis added), not, as the HMOs contend, to whether the complaint happens to reference the contract.

A couple of Texas cases directly illustrate the point. For example, in Fridl v. Cook, 908 S.W.2d 507 (Tex. App. 1995, writ dismissed w.o.j.), the court considered the arbitrability of various tort claims under an arbitration clause essentially mirroring the one in Dr. Ford's agreement. The plaintiff alleged claims based on fraud and tortious interference with contract. Because the complaint referenced the contract between the plaintiff and defendants, the defendants argued that the claims were arbitrable because they "related to" the contract. The court rejected the argument. With respect to the fraud claim, the court stated:

> We do not see that this is a claim "arising out of or relating to" the contract. [The defendants] may have honored their contractual obligations in every respect,

> and yet be liable for fraudulently inducing [the plaintiff] to obtain business outside the contract so as to avoid full payment of commissions. We believe this claim is distinguishable from the fraud claim which this Court found subject to arbitration in Merrill Lynch, Pierce, Fenner & Smith, Inc. v. Wilson, 805 S.W.2d 38, 40 (Tex. App.–El Paso 1991, no writ). There, Merrill Lynch could not be liable for fraud unless it had breached its obligations under the brokerage contract with Wilson, its client. Here, the fraud claim may be pursued even if no breach of the [] contract occurred. . . .

908 S.W.2d at 513. The court also applied this same analysis in holding that the tortious interference claim did not fall within the scope of the arbitration clause. Examining the legal elements of a tortious interference claim, the court concluded that the existence of the contract between the plaintiff and defendants was unnecessary to establish the claim. See id. The fact that the complaint specifically referred to, and related as a factual matter to, the contract containing the arbitration clause was irrelevant. The tort action did not depend, as a legal matter, on the contract and, therefore, was not "related to" the contract within the meaning of the arbitration clause.

Similarly, in Hearthshire Braeswood Plaza Ltd. Partnership v. Bill Kelly Co., 849 S.W.2d 380 (Tex. App. 1993, writ denied), the court refused to compel arbitration of a tort claim that was legally independent of the contract containing the arbitration agreement. Again, the relevant arbitration clause provided for arbitration of any dispute "arising out of or relating to"

the contract between the parties. See id. at 383. The plaintiff alleged that it had entered the contract with the defendant–involving a "Gardens" project–only because it had been promised another project–involving the "Landing." See id. at 391. The plaintiff advanced several tort claims against the defendant in connection with the Landing project. Holding that these claims were not arbitrable, the court observed that the plaintiff "need not even refer to the contracts involving the Gardens in order to maintain the claims regarding the Landing." Id. Thus, Hearthshire demonstrates that the test for whether a tort claim "relates to" a contract depends on whether the claim could be maintained without reference to the contract, not simply whether the complaint references the contract.

B

Applying this test to Dr. Ford's false advertising claim, we conclude that it does not arise out of or relate to his agreement with the HMOs. The basic elements Dr. Ford must allege to sustain a false advertising claim are: (1) that the HMOs made a false or misleading statement as to their services; (2) that there is actual deception or a tendency to deceive a substantial portion of the intended audience; (3) that the deception is material in that it is likely to influence purchasing decisions; (4) that the advertised services involve interstate commerce; and (5) that there is a likelihood of injury to Dr. Ford. See Seven-Up Co. v. Coca-Cola Co., 86 F.3d 1379, 1383 n.3 (5th Cir. 1996). n8 None of these elements depends, as a legal matter, on the agreement between Dr. Ford and the HMOs.

As the district court correctly determined, Dr. Ford could maintain this action without reference to the agreement. The action is based on the manner in which the HMOs advertised their services to consumers. The competitive injuries alleged by Dr. Ford come in the

form of patients and revenue lost as a result of consumers being misled into participating in the HMOs' health plan instead of going directly to the doctor of their choice and seeking reimbursement through the traditional health insurance route. n9 Dr. Ford clearly would suffer the same injuries regardless of the agreement or a breach thereof. Although the policies, practices, and procedures implemented by the HMOs, as they appear in the terms of the agreement, would undoubtedly be relevant evidence in support of Dr. Ford's claims (e.g., to show that the HMOs use procedures resulting in care different from that advertised), this evidence could likewise be established with witness testimony and documents, which exist independent of the agreement. In other words, the fact that an agreement exists between Dr. Ford and the HMOs is legally irrelevant and indeed can be treated as nonexistent as far as his false advertising claim is concerned. In fact, the agreement will likely play, even as a purely evidentiary matter, a very minor role in the ultimate litigation of Dr. Ford's false advertising claim. Thus, we hold that Dr. Ford's false advertising claim does not arise out of or relate to his agreement with the HMOs and, therefore, is not subject to the agreement's arbitration clause.

IV

For the foregoing reasons, the judgment of the district court is

AFFIRMED.

FOOTNOTES

n1 NYLCare was formerly known as "Sanus Texas Health Care Plan, Inc." Throughout this opinion,

NYLCare and New York Life will be referred to collectively as "the HMOs."

n2 In addition to NYLCare and New York Life, Dr. Ford also sued Aetna Health Plans of Texas, Inc., Aetna Life and Casualty Co., MetraHealth Care Plan of Texas, Inc., MetraHealth Insurance Co., United Healthcare Corp., Travelers Insurance Co., and Metropolitan Life Insurance Co. These defendants did not have arbitration clauses in their agreements with Dr. Ford and are not parties to this appeal.

n3 At oral argument, the HMOs confirmed that the agreements they maintained with other physicians were "virtually identical" to Dr. Ford's.

n4 Dr. Ford explained at oral argument that he limited the action to physicians who had contracted with the HMOs solely to assure an easily identifiable list of plaintiffs for whom the HMOs could provide telephone numbers and addresses.

n5 The parties apparently agree that the agreement here involves commerce.

n6 The HMOs' reliance on our decision in Atlantic Aviation for the proposition that substantive federal law governs the scope of an arbitration clause whenever the agreement involves commerce is misplaced. That case concerned whether parties could invoke a choice-of-law provision to limit the jurisdiction of federal courts to hear the appeal of an order vacating an arbitration award and directing a rehearing. See 11 F.3d at 1279. The jurisdiction of the federal courts is generally a matter for Congress to decide, not private parties or state law. Recognizing this principle, the court held that "the FAA governs judicial review of arbitration proceedings notwithstanding any choice of law provision or state law to the contrary." Id. at 1280. The court did not, however, extend its reasoning beyond the

issue of jurisdiction. Compare, e.g., Gateway Tech., Inc. v. MCI Telecomm. Corp., 64 F.3d 993, 996-97, 997 n.3 (5th Cir. 1995) (upholding parties' contractual choice to expanded review of the arbitration award by federal courts). Thus, Atlantic Aviation does not control the case before us. Although parties cannot use a choice-of-law provision to divest federal courts of jurisdiction, this limitation does not prevent parties from selecting state law to govern the scope of their agreement to arbitrate. And although Atlantic Aviation relied in part on earlier cases suggesting that the involvement of commerce under the FAA was dispositive with respect to the law governing arbitrability even where the parties contemplated state law to apply, see, e.g., Mesa Operating Ltd. Partnership v. Louisiana Interstate Gas Corp., 797 F.2d 238 (5th Cir. 1986), those cases did not survive Volt, which, as discussed above, expressly held otherwise. Atlantic Aviation, decided five years after Volt, should not be read to revive these cases in any way.

n7 We agree with the HMOs that there is no perceptible difference between the federal and Texas standards in this respect. Whether described as "touching matters covered by" the agreement, see Mitsubishi, 473 U.S. at 624 n.13, or "interwoven with" the agreement, see X.L. Insurance Co., 918 S.W.2d at 689, a tort claim is "related to" the agreement only if reference to the agreement is required to maintain the action. This is true notwithstanding the fact that the tort claim may implicate the agreement as a factual matter.

n8 Section 43(a) of the Lanham Act provides, in relevant part:

Any person who . . . in commercial advertising or promotion, misrepresents the nature, characteristics, qualities, or geographic origin of his or her or another

person's goods, services, or commercial activities, shall be liable in a civil action by any person who believes that he or she is likely to be damaged by such act.

15 U.S.C. § 1125(a).

n9 Dr. Ford, like the other doctors providing services under the HMOs' plan, maintains a private practice outside his relationship with the HMOs.

(Appendix C)

CIVIL ACTION NO. 96-1564

UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF TEXAS, HOUSTON DIVISION

KENNETH FORD,
Plaintiff,

v.

NYLCARE HEALTH PLANS OF THE GULF COAST, INC., ET AL., Defendants.

November 30, 1999, Decided

December 1, 1999, Entered

COUNSEL:
For KENNETH FORD, Dr, plaintiff: Kenneth R Wynne, Wynne & Maney, Houston, TX.

For NYLCARE HEALTH PLANS OF THE GULF COAST INC, NEW YORK LIFE INSURANCE COMPANY, defendants: Neal S Manne, James Hoke Peacock, III, Susman Godfrey, Houston, TX.

For AETNA HEALTH PLANS OF TEXAS, AETNA LIFE AND CASUALTY COMPANY, defendants: John Bruce Shely, Andrews and Kurth, Houston, TX.

For THE METRAHEALTH CARE PLAN OF TEXAS INC, THE METRAHEALTH INSURANCE COMPANY, UNITED HEALTHCARE INSURANCE COMPANY INC, TRAVELERS INSURANCE COMPANY, defendants: Wayne B Mason, Strasburger & Price, Dallas, TX.

For METROPOLITAN LIFE INSURANCE COMPANY, defendant: Layne Edwin Kruse, Fulbright and Jaworski, Houston, TX.

JUDGES:
DAVID HITTNER, United States District Judge.

OPINIONBY:
DAVID HITTNER

OPINION:

ORDER

Pending before the Court is the Motion for Class Certification filed by plaintiff Kenneth Ford ("Ford"). Having considered the motion, submissions, and applicable law, together with the arguments of counsel at a class certification hearing conducted by the Court, the Court determines that the motion for class certification should be denied.

Ford filed this suit on behalf of a proposed class of Board-certified physicians who have contracted with the various defendant HMO companies, alleging claims of false advertising under the Lanham Act, §43(a), 15 U.S.C. § 1125(a). Specifically, Ford alleges that the defendants violated the Lanham Act by misdescribing core features of their HMOs in advertising and promotional materials used to persuade prospective patients and their employees to subscribe to their plans. The named defendants are Aetna U.S. Healthcare, Inc. ("Aetna"), United HealthCare ("UHC"), and New York Life's HMOs, which operate under the name NYLCare and which have subsequently been acquired by Aetna.

The thrust of Ford's complaint is that defendant HMOs built substantial memberships on the basis of

false and misleading advertising. Specifically, the defendants' advertisements regarding the quality of health care provided by doctors in their words are misleading because these advertisements fail to tell consumers about certain practices of the HMOs, such as capitation, n1 utilization review, n2 and case management. n3 These procedures, contend the plaintiff, diminish the level of health care that doctors provide to consumers in favor of greater profits and are not mentioned in the advertisements. Thereafter, the defendants utilize the large numbers of their subscribers to reduce the amount of medical care those persons receive and as bargaining power, to force specialist physicians into contracts that reduce their fee for the medical services the defendants authorize.

Ford seeks certification of a national class of Board-certified physicians. Specifically, Ford has defined the potential class as n4:

> all specialist physicians (defined as board-certified specialists) who have contracted with a provider network of one of the defendants' HMO subscribers . . . but including only provider networks in operation since 1992, and excepting physicians who contracted to act as primary care-physicians or who were paid by capitation.

Ford argues that certification of a national class, versus a local or regional class, is appropriate because the policies of the defendants' and the defendants' marketing strategies are conducted on a national level.

Federal Rule of Civil Procedure 23(a)

In order to maintain a class action, a representative suit must comply with the requirements of each of the four subsections of Rule 23(a) and must satisfy the additional requirement of at least one of the three subdivisions of Rule 23(b). See 1 Herbert B. Newberg & Alba Conte, Newberg on Class Actions (3d ed. 1992), §4.01, at 4-3. Rule 23(a) of the Fed. R. Civ. P. provides:

> (a) Prerequisites to a Class Action. One or more members of a class may sue or be sued as representative parties on behalf of all only if: (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

Rule 23(b) provides:

> (b) Class Actions Maintainable. An action may be maintained as a class action if the prerequisites of subdivision (a) are satisfied, and in addition:
>
> > (1) the prosecution of separate actions by or against individual members of the class would create a risk of
> >
> > > (A) inconsistent or varying adjudications with respect to

individual members of the class which would establish incompatible standards of conduct for the party opposing the class, or

B) adjudications with respect to individual members of the class which would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests; or

(2) the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole; or

(3) the court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy. The matters pertinent to the findings include: (A) the interest of members of the class in individually controlling the prosecution or defense of separate actions; (B) the extent and nature of any litigation concerning the

> controversy already commenced by or against members of the class; (C) the desirability or undesirability of concentrating the litigation of the claims in the particular forum; (D) the difficulties likely to be encountered in the management of a class action.

The district courts must conduct a "rigorous analysis" into whether the prerequisites of Rule 23 are met before certifying a class. General Tel. Co. v. Falcon, 457 U.S. 147, 161, 72 L. Ed. 2d 740, 102 S. Ct. 2364 (1982). The party seeking the class certification bears the burden of proof. Applewhite v. Reichhold Chems., Inc., 67 F.3d 571, 573 (5th Cir. 1995).

The first prerequisite for class certification is numerosity. The defendants do not dispute that Ford has satisfied the numerosity requirement for certification.

Defendants argue that Ford cannot satisfy the typically requirement of Rule 23(a)(3). Rule 23(a)(3) requires that the party moving for class certification prove typicality of his claims, i.e., that the claims arise from the same event, practice, or course of conduct that gives rise to the claims of other class members. Defendants contend that Ford's Lanham Act claim is particularly ill-suited for class treatment.

To prevail on a Lanham Act claim, a plaintiff must show: (i) the statement made by the defendant was literally false, or was likely to mislead or confuse consumers; (ii) there is a tendency to deceive a substantial portion of the intended audience, (iii) the deception is material in that it is likely to influence purchasing decisions; (iv) the advertised goods traveled in interstate commerce; and (v) there is likelihood of injury to the plaintiff in terms of declining sales or loss

of goodwill. Pebble Beach Co. v. Tour 18 I. Ltd., 942 F. Supp. 1513, 1562 (S.D. Tex. 1996) (citing Johnson & Johnson-Merck Consumer Pharmaceuticals Co. v. Rhone-Poulenc Rorer Pharmaceuticals, Inc., 19 F.3d 125, 129 (3d Cir. 1994)).

The Court agrees that plaintiff cannot establish the required element of typicality of claims for the Lanham Act cause of action. To sustain his Lanham Act claim on behalf of the proposed class, plaintiff would have to show that each advertisement is false or has a tendency to deceive the intended audience. This inquiry necessarily depends on whether a particular consumer saw a particular advertisement, whether the consumer was misled by that advertisement, whether the alleged deception caused consumers to join the HMOs in question, and whether a particular physician was harmed by the alleged reduction in visits and fees for a particular patient. These questions, by their nature, are unique because they involve highly specific and individual factors that vary by defendant, advertisement, geographical location, sophistication of the target audience, familiarity of the audience with the HMOs, and the particular physician's particular medical speciality. Given these possible contingencies, each doctor's claim is unique and will depend on the resolution of individualized questions. Because of the existence of these individual questions, there is an absence in typicality between the proposed class members claims.

Defendant's next argue that plaintiff's claims are not typical of the class. First, defendants argue that plaintiff is not employed full time as a physician because he works less than forty hours per week and spends a significant period of time filming a fishing show for ESPN-2 Sports Network. Second, while the income of all of plaintiff's partners has risen during the period

between 1992-1996 plaintiff's annual income has declined. Thus, the defendants conclude that plaintiff's claims are not typical of those of the other members of the putative class because many of the putative class members have suffered no injury in that their annual incomes have increased.

The Court agrees with the defendants' analysis of the typicality of plaintiff's claims. Because Dr. Ford's claims do not arise from the same event, practice, or course of conduct as those of the putative members of the class, Dr. Ford is not a typical plaintiff.

The last requirement of Fed. R. Civ. P. 23(a) is that the class representative will fairly and adequately represent the interests of the class. The defendants have gone to great lengths to discredit Dr. Ford's ability to fairly and adequately represent the class. The defendants argue that Dr. Ford lacks adequate knowledge about this litigation or his role as a class representative and Dr. Ford has interests that are antagonistic to other members of the class.

The Court does not agree with the defendants' assessments of Dr. Ford's qualifications as a class representative. The Court determines that Dr. Ford would fairly and adequately represent the class, if a class were appropriate in this case.

Rule 23 of the Federal Rules of Civil Procedure require that in addition to satisfying the prerequisites of Rule 23(a), a party desiring to certify a class must also satisfy at least one of three prerequisites enumerated in Rule 23(b). Defendants argue that Dr. Ford cannot satisfy any of the subsections of Rule 23(b).

Federal Rule Civil Procedure 23(b)(3)

Rule 23(b)(3) provides:

Class Actions Maintainable: An action may be maintained as a class action if the prerequisites of subdivision (a) are satisfied, and in addition:

> (3) the court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy. The matters pertinent to the findings include: (A) the interest of members of the class in individually controlling the prosecution or defense of separate actions; (B) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class;(C) the desirability or undesirability of concentrating the litigation of the claims in the particular forum; (D) the difficulties likely to be encountered in the management of a class action.

The Court determines that the questions of law and fact that are relevant to the plaintiff's Lanham Act claims do not predominate over questions affecting individual members. As discussed above, the pertinent inquiry in establishing a violation of the Lanham Act is whether each member of the target audience was misled by a certain advertisement which caused them to join a certain HMO based on the misleading statements. Given that these inquiries are highly individualized, the Court cannot find that the issues common to the class

predominate over issues that affect the individual members of the class.

Nor can this Court find that the class action is the superior method for disposing of the putative class' claims. Matters pertinent to the consideration of whether a class action is a superior method of conducting litigation are: (i) the interest of members of the class in individually controlling the prosecution or defense of separate actions; (ii) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class; and (iii) the difficulties likely to be encountered in the management of the class action. In Allison v. CITGO Petroleum Corp, 151 F.3d 402 (5th Cir. 1998) the court stated that "the most compelling rationale for finding superiority in a class action [is] the existence of a negative value suit." A negative value suit is one in which the "stakes to each member [are] too slight to repay the cost of the suit." In re Rhone-Poulenc Rorer, Inc., 51 F.3d 1293, 1300 (7th Cir.), cert. denied, 516 U.S. 867, 133 L. Ed. 2d 122, 116 S. Ct. 184 (1995). Because plaintiff's alleged damages are more than $ 100,000, these damages are substantial. The Court also determines that the damages claims of the individual members of the class would be substantial. Thus, this suit cannot be classified as a "negative value suit."

Federal Rule Civil Procedure 23(b)(1)(A)

Rule 23(b)(1)(A) states that an action may be maintained as a class action if the adjudications of the individual members of the class would create a "risk" of "inconsistent or varying adjudications with respect to individual members of the class which would establish incompatible standards of conduct for the party opposing the class." Rule 23(b)(1)(A) is satisfied in the event that inconsistent judgments in separate suits would trap the party opposing the class "in the

inescapable legal quagmire of not being able to comply with one such judgment without violating the terms of another." McBirney v. Autrey, 106 F.R.D. 240, 245 (N.D. Tex. 1985) (quoting Walker v. City of Houston, 341 F. Supp. 1124, 1131 (S.D. Tex. 1971)). "In essence, Rule 23(b)(1) is concerned with the prejudicial effect which inconsistent judgments may have on the party opposing the class." Id. Because the defendants do not seek the protection of this section, it is not applicable in this case.

The plaintiff has not provided a compelling argument that the entry of several judgments against the defendants in this case would be inconsistent, as contemplated by the Rule. Accordingly, the Court determines that there has been an insufficient showing of risk that the defendants would be unable to comply with judgments for damages or injunctive relief for various claimants.

Federal Rule of Civil Procedure 23(b)(2)

Rule 23(b)(2) provides that "an action may be maintained as a class action if the prerequisites of subdivision (a) are satisfied, and in addition "(2) the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole." Fed. R. Civ. P. 23(b)(2). In order to satisfy the requirements of Fed. R. Civ. P. 23(b)(2), the proposed class action must involve a group harm or a group remedy. Allison v. Citgo Petroleum Corp., 151 F.3d 402, 413 (5th Cir. 1998). Plaintiff has failed to establish that the members of the proposed class are "homogeneous and cohesive group," as contemplated by the Rule. Id. Rather the testimony adduced at the class certification hearing reveals that certain potential class members are in competition with each other and

compete with each other for new patients. This finding negates against a conclusion of homogeneity and cohesiveness.

Further, Rule 23(b)(2) does permit that "monetary relief may be obtained in a (b)(2) class action so long as the predominant relief sought is injunctive or declaratory." Id. at 411. The Court determines that while the plaintiff is seeking injunctive relief in this case, it is not the predominate relief sought. Rather, plaintiff seeks monetary relief in the form of actual damages, punitive damages, and attorneys fees. Thus, plaintiff's claims do not qualify for Rule 23(b)(2) certification.

As the plaintiff has failed to satisfy the prerequisites for class certification pursuant to Rule 23 of the federal rules of certification, the Court determines that class certification is not appropriate for the claims in this case.

Therefore, based on the foregoing, the Court hereby

ORDERS that the Motion for Class Certification is DENIED.

SIGNED at Houston, Texas on this the 30 day of November, 1999.

DAVID HITTNER

United States District Judge

FOOTNOTES

n1 Capitation refers to the system of compensation for physicians by the HMOs whereby the physical is paid a fixed amount per month per patient assigned to a physician regardless of how many times a month the patient visits the physician's office.

n2 Utilization review refers to the process whereby HMOs require authorization for proposed treatments.

The proposed treatments are compared against a standardized guide licensed from commercial third party providers.

n3 Case management refers to the HMO practice of assigning a nurse to monitor the medical treatment of certain very ill patients to guarantee that the proposed treatment is within standardized guidelines of care.

n4 The defendants are opposed to this definition as it represents an amendment of plaintiff's prior class definition, which defendant argues should not be permitted at this time. Moreover, the defendants argue that under this definition, Ford would be excluded from the class as he and his group, the Southwest Bone and Joint Clinic, were contracting providers in defendant NYLCare's provider network and were paid by capitation. Therefore, the defendants contend that Ford himself would be excluded from the class, leaving no other class representative.

(Appendix D)

Civil Action # H-96-1564

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

DR. KENNETH FORD,
Plaintiff,

v.

NYLCARE HEALTH PLANS OF THE GULF COAST,
INC., et. al.,
Defendants

Entered April 10, 2001

ORDER

Pending before the Court is Defendants' Motion for Summary Judgment (Document #231). Having considered the motion, submissions, and application of law, the Court determines that the motion for summary judgment should be granted.

I. BACKGROUND

Plaintiff Dr. Kenneth Ford ("Ford") is an orthopedic surgeon who alleges that commercial advertising of managed health care is false and misleading. In May 1996, Ford filed suit against several health maintenance organizations ("HMOs").fn1

Ford originally asserted multiple causes of action against the HMOs for their allegedly deceptive

advertising practices. After five years and numerous rulings by this Court, what remains of Ford's case is a claim of false advertising pursuant to section 43(a) of the Lanham Act, 15 U.S.C. § 1125(a) ("section 43(a)"), against Defendants Aetna and United.fn2 Ford seeks injunctive and declaratory relief and recovery of attorneys' fees. Defendants now seek summary judgment, asserting that Ford lacks standing under the Lanham Act and that he has no evidence on essential elements of his section 43(a) claim.

II. SUMMARY JUDGMENT STANDARD

Summary judgment is mandated "against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986). Initially, the movant bears the burden of demonstrating to the court that there is an absence of a genuine issue of any material fact. Id. at 323. The burden then shifts to the party who bears the burden of proof on the claims on which summary judgment is sought to present evidence beyond the pleadings to show there is a genuine issue for trial. Id. at 324. A genuine issue for trial exists when "there is sufficient evidence favoring the nonmoving party for a jury to return a verdict for that party. If the evidence is merely colorable, or is not significantly probative, summary judgment may be granted." Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 249-50 (1986).

III. FORD'S ALLEGATIONS

Ford contends that Defendants have engaged in deceptive and unlawful practices that sacrifice their duties to their beneficiaries and the doctors who treat

them "on the altar of their own greed." Ford asserts that "with the lure of deceptive advertisements, the Defendants are amassing an ever growing percentage of the health care market in this country, tying large number of Americans into managed care programs where the Defendants can dictate who their treating doctors will be and then impose on those doctors restrictions and payment schemes designed to reduce the level of health care provided."

Ford alleges that Defendants falsely advertise that their customers' medical care will be managed by their own doctors and that Defendants use premium dollars efficiently to provide quality health care, indeed to improve its quality from that historically provided. Ford contends that this advertising is persuasive but false because it fails to disclose that the HMOs are:

- themselves managing the care provided under their plans;

- diverting an inordinate amount of the premium dollars to profits instead of health care;

- providing the cheapest health care possible by using the lowest bidders for the services;

- inhibiting the delivery of quality health care by undisclosed, inappropriate procedures, including putting primary care doctors into financial conflicts of interest in recommending treatment and referrals to patients;

- wresting control over patients' care from the treating physician and reposing it in the Defendants; and

- refusing to pay and/or underpaying for appropriate procedures.

Ford states that while Defendants promise their beneficiaries cost effective and high quality health care, they instead provide a "labyrinthine" system that ultimately denies effective health care and supplants it with windfall profits for themselves. This is achieved, according to Ford, by discouraging doctors from providing appropriate care or by outright denying coverage or payment for needed treatment. Ford also argues that the Defendants' management scheme entails far greater administrative costs than traditional insurance.

Ford further argues that Defendants' advertising is false and misleading because it omits material information that is necessary to correct the misleading nature of their statements regarding their products and services. For example, Ford states that the advertising omits information such as "defendants offer bargain rate health care in which a patient's care, in many case[s], is relegated to the lowest bidder and cheapest treatment option," that "physicians are provided incentives and pressures . . . to reduce the level of health care provided," and that "defendants' management plan can cause . . . significant delays in treatment due to the requirements for pre-authorization by the defendants."

Ford believes that one of the most deceptive misrepresentations by Defendants involves their portrayal of gate-keeper doctors as a health benefit. Ford contends that by comparing HMOs to a traditional

doctor-patient relationship, and by claiming that HMOs are superior to that relationship, Defendants are engaging in false comparative advertising.

Defendants argue that they are entitled to summary judgment on two grounds: (1) Ford lacks standing under the Lanham Act, and (2) Ford has no evidence on essential elements of his section 43(a) claim. As the Court determines that Ford lacks standing, it will only address that issue herein.

IV. SECTION 43 (A) STANDING

In their motion for summary judgment, Defendants ask the Court to reconsider its ruling that Ford had standing to bring the instant action.fn3 Given recent Fifth Circuit authority on this exact issue, the Court agrees that it is appropriate to revisit the question of standing.

Defendants assert that Ford lacks standing because he is not a competitor of Defendants. Defendants do not (and cannot) perform orthopedic surgery nor employ physicians for the purpose of performing orthopedic surgery or any other medical procedure. Conversely, Ford does not offer managed care products, medical insurance, a provider network, or benefits administration services to the general public; in fact, such competition would be illegal as Ford has no license to engage in the managed care business. Moreover, Defendants assert that Ford does not compete for the health care dollar with Defendants because there is no proof that he loses patients and/or income when patients become a member of Aetna or United. In fact, Ford himself is still under contract with HMOs. Defendants thus contend that there is no direct nor indirect competition among Ford and Defendants and,

accordingly, Ford lacks standing. Ford responds that he has standing because HMOs cut medical costs, including doctors' incomes and fees, which shows a logical connection between a rise in HMO membership and his commercial interests.

The Fifth Circuit recently addressed the issue of section 43(a) standing, determining that Congress intended to limit standing to a narrow class of potential plaintiffs under the Lanham Act. Procter & Gamble Co. v. Amway Corp., No. 99-20590, 2001 WL 125310, at * 18 (5th Cir. Feb. 14, 2001).fn4 The Procter & Gamble court identified the following factors to be considered in determining section 43(a) standing:

> 1. The nature of the plaintiff's alleged injury;
>
> 2. The directness or indirectness of the asserted injury;
>
> 3. The proximity or remoteness of the party to the alleged injurious conduct;
>
> 4. The speculativeness of the damages claim; and
>
> 5. The risk of duplicative damages or complexity in apportioning damages.

Id. At least four of the Procter & Gamble factors weigh against Ford's standing.

The first factor, nature of the alleged injury, directs the Court to decide whether the alleged injury is of a type Congress sought to redress in providing a private remedy for violations of the Lanham Act. Id. Regarding

this inquiry, the Fifth Circuit recognized that the focus of the Lanham Act is on commercial interests that have been harmed by a competitor's false advertising. Id. at * 19. Here, the alleged harm—lower fees and incomes for doctors like Ford as a result of managed care advertising—is not the type of injury that Congress sought to redress in enacting section 43(a). See Id. (noting that the ultimate result of lower sales was not the type of injury that Congress sought to redress in the Lanham Act).

The second factor, the directness of the alleged injury, is of particular concern to Ford's case. As the Fifth Circuit stated in Procter & Gamble, "[i]f standing is allowed here, one could argue that any competitor's fraudulent act in running its business that gives it an advantage could be sued upon as a violation of the Lanham Act. Opening up standing to this extent would not be prudent." Id. Although the facts of the instant dispute are different than those in Procter & Gamble, the basic argument by the plaintiff is the same: Ford argues that the HMOs' advertising of their managed care ultimately results in lower fees and incomes for doctors like Ford. For the reasons the Fifth Circuit articulated in Procter & Gamble, allowing Ford standing in these circumstances "would not be prudent." See id.

The third factor, the proximity of the party to the alleged injurious conduct, similarly weighs against standing. Ford claims that managed care harms him generally (even though he is voluntarily under contract with the HMOs) and that the Defendants are increasing their market share by "duping" prospective members. If Defendants' members (i.e., patients) feel that they have been lied to or misled, they are free to vindicate the public interest themselves. See Id. (citing Assoc. Gen. Contractors of Cal., Inc. v. Cal. State Council of

Carpenters, 459 U.S. 519, 542 (1983), for the proposition that "the existence of an identifiable class of persons whose self-interest would normally motivate them to vindicate the public interest . . . diminishes the justification for allowing a more remote party. . . to perform the offices of a private attorney general").

The fourth factor, speculativeness of the damages, weighs neither for nor against Ford's standing. Ford has dropped his claim for monetary damages, explaining that it was "uneconomical" for him to pursue damages given the Court's denial of class certification. Ford now seeks only declaratory and injunctive relief as well as attorneys' fees. The Court thus declines to comment on whether his damages would be so "speculative" so as to weigh in favor of or against standing.

Finally, the fifth factor, the risk of duplicative damages or complexity of apportioning damages, strongly cautions against standing. If Ford were allowed standing in this case, the Fifth's Circuits fears of "a great increase in marginal litigation" would almost certainly be realized. See id. at *20. Indeed, every doctor who preferred traditional insurance and believed that managed care advertising adversely affected his or her income could be a potential plaintiff. This would not serve the purpose of the Lanham Act. See id. at *19-20. Accordingly, the totality of the Procter & Gamble factors weigh heavily against Ford's standing in the instant suit. The Court therefore determines that Ford lacks standing in his section 43(a) claim, and summary judgment in favor of Defendants is appropriate. Given the foregoing, the Court hereby

ORDERS that Defendants' Motion for Summary Judgment (Document #231) is GRANTED. Plaintiffs section 43(a) claims are DISMISSED.

SIGNED at Houston, Texas, on this 9 day of, April, 2001.

DAVID HITTNER
United States District Judge

Footnotes

fn1 Original Defendants included NYLCare Health Plans of the Gulf Coast, Inc., New York Life Insurance Co., Aetna U.S. Healthcare Inc., United HealthCare Plan of Texas, Inc. f/k/al MetraHealth Care Plan of Texas, Inc., United HealthCare Insurance Co. f/k/a/ The MetraHealth Insurance Co., United HealthCare Corp., Travelers Insurance Co., and Metropolitan Life Insurance Co.

fn2 "Aetna" refers to Aetna U.S. Healthcare, Inc. f/k/a Aetna Health Plans of Texas, Inc. and Aetna U.S. Healthcare Inc., substituted by court order for Aetna Life and Casualty Co. "United" refers to United HealthCare of Texas, Inc. f/k/a/ The MetraHealth Care Plan of Texas, Inc., United HealthCare Insurance Co. f/k/a The MetraHealth Insurance Co., and United HealthCare Corp.

fn3 In its January 3, 1997 order on defendants' motion to dismiss, the Court determined that Ford had standing as he had sustained a discernibly competitive injury.

fn4 The standing test applies to both false association claims and false advertising claims. See id. at *17-18.

(Appendix E)

No. 01-20610, No. 01-21255

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

KENNETH FORD, DR.,
Plaintiff-Appellant,

VERSUS NYLCARE HEALTH PLANS OF THE GULF COAST, INC., ET AL.,
Defendants,

AETNA U.S. HEALTHCARE, INC., A TEXAS CORPORATION; THE METRAHEALTH CARE PLAN OF TEXAS, INC.; THE METRAHEALTH INSURANCE COMPANY; UNITED HEALTHCARE INSURANCE COMPANY, INC.; AETNA U.S. HEALTHCARE, INC., A PENNSYLVANIA CORPORATION,
Defendants-Appellees.

August 1, 2002, Decided

COUNSEL:
For KENNETH FORD, Plaintiff – Appellant: Kenneth R Wynne, Mark E Maney, Wynne & Maney, Houston, TX.

For METRAHEALTH CARE PLAN OF TEXAS INC, METRAHEALTH INSURANCE CO, UNITED HEALTHCARE INSURANCE COMPANY, INC, Defendants – Appellees: Paula Denney, Strasburger & Price, Houston, TX. P Michael Jung, Strasburger & Price, Dallas, TX.

For AETNA US HEALTHCARE INC, Defendant – Appellee: John Bruce Shely, Kendall Matthew Gray,

Andrews & Kurth Mayor, Day, Caldwell & Keeton, Houston, TX.

JUDGES:

Before SMITH, BENAVIDES, and PARKER, Circuit Judges. FORTUNATO P. BENAVIDES, Circuit Judge, Specially Concurring.

OPINION BY:

JERRY E. SMITH

OPINION:

JERRY E. SMITH, Circuit Judge:

I.

Kenneth Ford is an orthopedic surgeon who has contracted with various health maintenance organizations ("HMO's") as a specialist. In May 1996, he sued the defendant HMO's, claiming multiple causes of action stemming from their allegedly deceptive advertising. All of Ford's claims were dismissed over a period of several years.

Ford now appeals two of the district court's rulings: its 1999 decision to deny class certification to a proposed Lanham Act plaintiff class of all certified physicians who have contracted with the defendant HMO's, and its 2001 summary judgment dismissing Ford's individual Lanham Act false advertising claim on the ground that he lacks prudential standing.

Ford contends that the HMO's have used false advertising that claims that their management techniques improve health care quality and that they allow patients and doctors to make their own treatment decisions. Ford argues that the defendants' cost-control measures undercut quality and "ration" medical care—sometimes against the will of doctors and patients. Ford

contends that the defendants' cost-control policies reduce the incomes of doctors, including his own. He also claims that, by attracting new customers to the HMO's' health plans, the allegedly deceptive advertising further reduces doctors' incomes because it increases the HMO's' market power over the price of medical services. We affirm the dismissal of Ford's claims for lack of Article III standing.

II.

A.

The relevant portion of the Lanham Act provides for a cause of action as follows:

> [HN1] (a) Civil action
>
> > (1) Any person who, on or in connection with any goods or services, or any container for goods, uses in commerce any word, term, name, symbol, or device, or any combination thereof, or any false designation of origin, false or misleading description of fact, or false or misleading representation of fact, which—
> > (A) is likely to cause confusion, or to cause mistake, or to deceive as to the affiliation, connection, or association of such person with another person, or as to the origin, sponsorship, or approval of his or her goods, services, or commercial activities by another person, or
> > (B) in commercial advertising or promotion, misrepresents the nature, characteristics, qualities, or geographic origin of his or her or another person's goods, services, or commercial activities, shall be liable in a civil action by any

> person who believes that he or she is or is likely to be damaged by such act.

15 U.S.C. § 1125(a) (1994). The district court held that Ford lacks prudential Lanham Act standing under this section. *See Procter & Gamble Co. v. Amway Corp., 242 F.3d 539, 560-62* (5th Cir.) (outlining test for determining prudential Lanham Act standing), *cert. Denied, 122 S. Ct. 329 (2001)*. Although Article III constitutional standing was not raised by the parties or considered by the district court, [HN2] we must—where necessary—raise it *sua spon te. SEC v. Forex Asset Mgmt., LLC, 242 F.3d 325, 328 (5th Cir. 2001)*. N1

[HN6] Standing "is an essential and unchanging part of the case-or-controversy requirement of Article III." *Lujan v. Defenders of Wildlife, 504 U.S. 555, 560, 119 L. Ed. 2d 351, 112 S. Ct. 2130 (1992)*.

> [HN7] [The irreducible constitutional minimum of standing contains three elements. First, the plaintiff must have suffered an 'injury in fact'—an invasion of a legally protected interest which is (a) concrete and particularized . . . and (b) actual or imminent not conjectural or hypothetical . . . Second, there must be a causal connection between the injury and the conduct complained of . . . Third, it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.

Id. At 560-61 (quotations omitted).

"The party invoking federal jurisdiction"—Ford—bears the burden of proof in es tablishing all three elements. *Id. At 561*. "Failure to establish any one [of

them] deprives the federal courts of jurisdiction to hear the suit." *Rivera v. Wyeth-Ayerst Labs., 283 F.3d 315, 319 (5th Cir. 2002).* [HN8] At the summary judgment stage, "the plaintiff can no longer rest on . . . mere allegations, but must set forth by affidavit or other evidence specific facts" validating his right to standing. *Lujan, 504 U.S. at 561* (citations omitted). The question of Article III standing must be decided prior to the prudential standing and class certification issues raised in this appeal, "because it determines the court's fundamental power even to hear the suit." N2 *Rivera, 283 F.3d at 319.* n3 Ford cannot prove the causation necessary to establish Article III standing.

B.

Ford claims that his injury consists of a re duction in his income from his medical practice caused by the defendants' restrictive cost-containment policies, which allegedly have the effect of reducing payments to contract specialists. He contends that the HMO's have been able to lower their payments to contract physicians as a result of increased market power gained by attracting patients through deceptive advertising. This argument fails to satisfy the causation prong of standing.

To meet the causation requirement, Ford would have to present evidence affirmatively proving that the reduction in his income was a consequence of the HMO's' restrictive policies and that those policies in turn were established or at least made more onerous as a result of increased market power created by the acquisition of new customers through the defendants' allegedly deceptive ads. N4 Nothing in the record establishes the validity of either of the two links in this causal chain, and Ford must provide evidence of both if he is to establish the causation necessary for Article III standing. Otherwise, he cannot show that his injury is

"fairly traceable to the challenged action of the defendant." *Lujan, 555 U.S. at 560* (quotations and ellipses omitted).

There is no evidence in the record to show that Ford's income has in fact declined any more than would be expected as a result of events completely unrelated to the HMO's' activities. When asked by opposing counsel whether he "could identify a single patient you lost as a result of the defendants' ads," Ford admitted that he could not. There is also no evidence demonstrating that Ford ever received a lower payment for his services than he would have in the absence of the advertisements.

In its ruling denying Ford's petition for class certification, the district court noted that, during the 1992-96 period, Ford's income did indeed decline, but the income of all of his partners went up. *Ford v. NYLCare Health Plans, Inc., 190 F.R.D. 422, 426 (S.D. Tex. 1999)*. The district court also pointed out that some or all of the decrease in Ford's income might have been a result of the fact that "he is not employed full time as a physician . . . and spends a significant period of time filming a fishing show for a sports network." *Id.* Ford bears the burden of proving otherwise, and he has not met it. N5

AFFIRMED.

CONCURBY:
FORTUNATO P. BENAVIDES,

CONCUR:

FORTUNATO P. BENAVIDES, Circuit Judge, Specially Concurring:

Although I would reach the same result as the majority, I write separately because I would base my analysis not on Article III standing, but on prudential standing under the Lanham Act. As the majority notes, Article III has never been raised as an issue in this case. It was never briefed by the parties, questioned by the district court, or even mentioned at oral argument. The parties did not have the benefit of a hearing to present evidence on the issue. Nevertheless, despite the complete absence of any suggestion that Article III standing might be deficient, the majority requires Dr. Ford to have adduced evidence of causation between the alleged false advertising and his asserted economic injury. Concluding that he has not met this burden, it holds that Article III standing is lacking.

Of course, the jurisdictional issue of standing may be raised *sua sponte* despite the parties' failure to raise it. *Henderson v. Stalder, 287 F.3d 374, 379 n.5 (5th Cir. 2002)*. The burden of establishing standing, which rests on the party invoking federal court jurisdiction, varies depending upon the stage at which standing becomes an issue. *Lujan v. Defenders of Wildlife, 504 U.S. 555, 561, 119 L. Ed. 2d 351, 112 S. Ct. 2130 (1992)*. At the pleading stage, we look only to the sufficiency of the allegations. *Id.* "In response to a summary judgment motion, however, the plaintiff can no longer rest on such 'mere allegations,'" but must adduce evidence in support of the elements of standing. *Id.* (quoting Fed. R. Civ. P. 56(e)). At the final stage of the litigation, standing must be supported adequately by the evidence offered at trial. *Id.*

Citing *Lujan* for support, the majority assumes that the summary judgment standard should govern even when the issue is raised *sua sponte* by an appellate court without notice to the parties. *Lujan*, however, does not go so far. It holds only that the summary

judgment standard is appropriate in reviewing a party's "*response to a summary judgment motion.*" *Id.* (emphasis added). This distinction is significant because it implicates concerns of notice and fairness. If the defendant challenges standing in a motion for summary judgment, then the plaintiff is able to direct the court to the evidence that supports federal jurisdiction. Similarly, if the court provides an opportunity for briefing after the issue is raised *sua sponte*, there is no risk of unfairness to the plaintiff. By contrast, if the appellate court raises the issue *sua sponte* without notice to the parties, the plaintiff is deprived of a meaningful opportunity to address the court's concerns by identifying record evidence to satisfy the standing requirements. *Cf.* *St. Paul Mercury Ins. Co. v. Williamson, 224 F.3d 425, 435 (5th Cir. 2000)* (requiring the district court to provide party with ten days notice and opportunity to respond before summary judgment is entered *sua sponte*).

In situations where a party has not been afforded an opportunity to respond to a court's *sua sponte* concerns about standing, it would be unfair to broaden review beyond the sufficiency of the pleadings. For example, in *Church v. City of Huntsville, 30 F.3d 1332, 1336 (11th Cir. 1994)*, the Eleventh Circuit confronted the issue of what standard to apply when the litigation had progressed beyond the stage of a motion to dismiss, but without any challenge to standing in the district court. In that case, the plaintiffs had obtained a preliminary injunction, but neither the defendants nor the district court ever questioned the existence of standing. The Eleventh Circuit recognized that although it was proper for the issue to be raised for the first time on appeal, "as a matter of fairness, the [defendant's] failure to question the plaintiffs' standing in the district court does affect the standard to which we will hold plaintiffs at this stage of the proceedings." *Id.* A plaintiff should be expected,

without prodding from the court or the opposing party, to file a complaint that sufficiently alleges standing and to prove such facts at trial. Still, the Eleventh Circuit understood that "it might well be unfair, however, to impose a standing burden beyond the sufficiency of the allegations of the pleadings on a plaintiff seeking a preliminary injunction, unless the defendant puts the plaintiff on notice that standing is contested." *Id.* Accordingly, the court determined that the standing issue should be judged based on the allegations in the complaint. *Id.* I see no reason why this same concern about notice and fairness should not affect the standard of review at the summary judgment stage.

Certainly, in some cases it will make no difference which standard is applied to a *sua sponte* challenge to standing. In such cases, the potential for prejudice is *de minimis* because the party's response will be futile. For example, a review of the record by the appellate court might indicate that there is an independent factor that precludes the plaintiff from ever demonstrating that his injury flows from the defendant's wrongful conduct. Such a factor was present in *Joint Stock Soc'y v. UDV N. Am., Inc., 266 F.3d 164 (3d Cir. 2001)*, which is cited by the majority. In *Joint Stock*, the Third Circuit affirmed a district court's determination that constitutional standing was lacking in a Lanham Act false advertising case brought by producers of Russian vodka against the American makers of the "Smirnoff" brand of vodka. *Id. At 168.* The Russian producers alleged *inter alia* that the Americans were misrepresenting the origin and historical pedigree of their Smirnoff vodka, which in fact was made in the United States and not endorsed by the original Smirnov family. *See id. At 177-78.* Holding that there was no evidence of a causal connection between the asserted injury and the allegedly false ads, the court pointed to the fact that the plaintiffs did not have superior

trademark rights to the Smirnoff brand, without which they could not have marketed their vodka in the United States under the Smirnoff name. *See id. At 178.* In light of this "independent cause," the Russian producers would be unable to use the Smirnoff name in the United States regardless of whether the American makers were engaging in false advertising. *See id.* In cases like *Joint Stock*, where it will be logically impossible to establish standing, there is no need to provide the party with an extra opportunity to identify evidence in support of a fatally flawed theory.

In other cases, prejudice will be minimized by the fact that the party has notice of the need to adduce evidence in support of Article III even though neither the court nor the defendant makes a formal motion. For example, in *Bischoff v. Osceola County, Fla., 222 F.3d 874, 882 n.8 (11th Cir. 2000)*, the Eleventh Circuit held that it was proper for the district court to apply a summary judgment standard on a *sua sponte* challenge to standing because the plaintiffs were on notice that standing was an issue, as they raised it themselves in briefs. Similarly, to the extent that identical issues have already been raised in the litigation, the threat of procedural prejudice is greatly diminished. *See Bridgeway Corp. v. Citibank, 201 F.3d 134, 140 (2d Cir. 2000)* (recognizing reduced threat of procedural prejudice where court's *sua sponte* determination is based on issues identical to the raised by the moving party). In the present case, although defendants had already attacked Dr. Ford's prudential standing under the Lanham Act, this issue is not identical to constitutional standing under Article III.

Applying these principles to the present case, before reaching *sua sponte* the conclusion that Dr. Ford has not met his summary judgment burden, I would ask whether a response would be futile. Notwithstanding

the majority's well-written and thoughtful analysis, I am unconvinced that affording Dr. Ford an opportunity to respond to our concerns about standing would be an exercise in futility. There is no dispute that Dr. Ford could survive a challenge to standing based solely on the sufficiency of his pleadings. His complaint alleges that the defendants have increased their customer base through deceptively false advertising, have leveraged that increased customer base to obtain lower fee arrangements for Dr. Ford's contract services, and have therefore caused him economic injury. Clearly, these allegations satisfy the requirements of Article III. The issue, as the majority notes, is whether there is evidence to support these links in the causal chain. The majority cites several failings in the record evidence, but none of them are fatal to Dr. Ford's theory. It notes that in a deposition, Dr. Ford was unable to identify a single patient lost as a result of the HMOs' ads. Although such evidence would undoubtedly be helpful to his case, it is by no means a necessary element. In Lanham Act § 43(a) cases, it is often difficult, if not impossible, to point to specific evidence of lost sales. *See Coca-Cola Co. v. Tropicana Products, Inc., 690 F.2d 312, 316 (2d Cir. 1982)* ("It is virtually impossible to prove that so much of one's sales will be lost or that one's goodwill will be damaged as a direct result of a competitor's advertisement. Too many market variables enter into the advertising-sales equation."); *Grant Airmass Corp. v. Gaymar Indus., Inc., 645 F. Supp. 1507, 1514 (S.D.N.Y. 1986)* (rejecting requirement that plaintiff must identify "a lost customer actually misled by the advertising literature"). This difficulty in identifying specific lost sales is further exacerbated by the immense complexity of the market at issue in this case. Decisions about plans and providers are influenced by a myriad of factors, and the ads are targeted at both the users (employees) and the purchasers (employers) of the

managed care plans. It is not unsurprising, therefore, that Dr. Ford could not name a single lost patient, and his failure to do so certainly does not mean that standing is lacking.

Similarly, the fact that Dr. Ford now spends part of his time hosting a fishing show on a sports television network does not preclude standing. As the majority notes, this observation was part of the district court's analysis of Dr. Ford's petition for class certification. Specifically, it found Dr. Ford's television work relevant to the typicality issue under Fed. R. Civ. P. 23(a)(3), as Dr. Ford's economic situation might not be similar to that of the other putative class members. *See Ford v. NYLCare Health Plans, Inc., 190 F.R.D. 422, 426 (S.D. Tex. 1999).* Typicality aside, however, the possibility that Dr. Ford's income has declined due to an increase in the hours he spends fishing does not mean that he has not also suffered economic injury as a result of the defendants' false ads. Such evidence goes not to the existence, but the quantum of injury. All that is required for Dr. Ford to have standing is "an identifiable trifle" of an injury. *Assoc. of Cmty. Orgs. For Reform Now v. Fowler, 178 F.3d 350, 358 (5th Cir. 1999)* (citations omitted). His work on the fishing program therefore is practically irrelevant to the standing issue.

In sum, I think it is premature to apply the summary judgment standard to Dr. Ford's standing under Article III. He has not been given an opportunity to identify the evidence in support of standing, and there has been no convincing argument that such an opportunity would be futile. Accordingly, I would not decide this case on Article III grounds, but would reach the same result by holding that Dr. Ford lacks prudential standing under the Lanham Act. Regardless of the oft- repeated maxim that Article III standing is jurisdictional and must be resolved prior to any analysis of the remaining issues in

the case, "it is entirely appropriate to deny standing on prudential grounds if that course is easier, or more clearly right, than to rule on constitutional grounds first." 13A Charles Alan Wright, et al., *Federal Practice and Procedure*, § 3531.15 (2d. ed. Supp. 2002); *cf. Steel Co. v. Citizens for a Better Env't, 523 U.S. 83, 92, 140 L. Ed. 2d 210, 118 S. Ct. 1003 (1998)* (disapproving of "hypothetical jurisdiction" cases in which standing is assumed in order to address clear merits issue, but distinguishing "cases in which a statutory standing question was decided before a question of constitutional standing"). In this case, prudential standing was briefed by the parties and ruled on by the district court, so nothing prevents us from holding Dr. Ford to his burden of identifying evidence demonstrating a genuine issue of material fact on the issue.

I would conclude that Dr. Ford has failed to satisfy his summary judgment burden on the issue of prudential standing under the Lanham Act. In determining whether a plaintiff has prudential Lanham Act standing, we have recently adopted the test articulated by the Third Circuit in *Conte Bros. Auto., Inc. v. Quaker State-Slick 50, Inc., 165 F.3d 221, 233-34 (3d Cir. 1998). See Procter & Gamble Co. v. Amway Corp., 242 F.3d 539, 562-63 (5th Cir 2001)* ("*P & G*"). Under this test, five factors are relevant to the prudential standing analysis: "(1) the nature of the plaintiff's alleged injury . . . (2) the directness or indirectness of the asserted injury; (3) the proximity or remoteness of the party to the alleged injurious conduct; (4) the speculativeness of the damages claim; and (5) the risk of duplicative damages or complexity in apportioning damages." *Id. At 563.* Although technically distinct, these five factors can be distilled into an essential inquiry, i.e., whether, in light of the competitive relationship between the parties, there is a sufficiently direct link between the asserted injury

and the alleged false advertising. *Cf. id. At 562 n.51* (citing Restatement (Third) of Unfair Competition § 3 cmt. F (1995)).

As the primary focus of the Lanham Act is on commercial harms that result from anti-competitive behavior, the first factor looks to the nature of the plaintiff's alleged injury. *See id. At 563* (quoting *Conte Bros.,165 F.3d at 234)*. Dr. Ford's asserted injury, while certainly a commercial harm, is competitive only in the most attenuated sense. He describes his injury as the lost income resulting from lower contract fees paid by HMOs. He attributes the HMOs' ability to demand such reductions to the increased bargaining power provided by a wider customer base, the fruits of the false advertising. Dr. Ford's essential complaint, therefore, is that the false ads are pulling customers away from plans that compensate him better and into HMOs, which secure reduced fee arrange ments. The main *competitive* effect of the ads, therefore, is felt adversely by other insurance plans, not by Dr. Ford. He himself is hurt only because the HMOs then exploit their competitive advantage over other plans to press physicians to accept lower compensation arrangements. Because this harm is only tangentially related to competition, it is not the "type that Congress sought to redress" in passing the Lanham Act. *See Conte, 165 F.3d at 234* (citation omitted).

Turning to the second factor, we have never required a direct competitive relationship between the plaintiff and the defendant. In fact, the *Conte* test specifically rejected such a requirement. *See Conte, 165 F.3d at 231-32.* Instead, the central issue is whether a plaintiff has "a reasonable interest to be protected against false advertising." *Id. At 231.* Again, the complexity of the relationship between Dr. Ford and the HMOs cuts against Lanham Act standing. Even though a plaintiff

can suffer a Lanham Act injury through indirect competition, such competition between Dr. Ford and the HMOs is so tenuous that it borders on the hypothetical. He does not provide health insurance and the HMOs do not provide direct patient care. In the absence of managed care plans, patients would come to Dr. Ford though traditional indemnity or fee-for-service insurance coverage. Theoretically, patients could seek his services without going through an insurance plan, but Dr. Ford has provided no evidence that such customers represent a significant portion of the market. In the absence of a group of consumers that would come to him directly but for the HMOs' deceptive ads, his injury is too indirect to support Lanham Act standing.

Applying the third factor, which looks to "the proximity of the party to the alleged injurious conduct," we have held that the justification for Lanham Act standing is diminished if there is "an identifiable class of persons whose self-interest would normally motivate them to vindicate the public interest" by bringing a Lanham Act claim. *P & G, 242 F.3d at 563* (citation omitted). As consumers do not have standing under the Lanham Act, they should be irrelevant to this analysis. *Cf. id. At 563-64* (noting that consumers do not have standing under the Lanham Act and focusing on rights of distributors). Moreover, we need not take into account consumers' ability to sue for fraud. Otherwise, as consumers would presumably almost always be able to bring an action for fraud, this factor would never counsel in favor of standing. In the present case, however, Dr. Ford has presented no evidence that physicians are the only class of persons motivated to bring a Lanham Act claim. Certainly, we should exclude from the possible alternatives other HMOs, as the ads in question tout the benefits of HMOs in general, not some specific companies over others. Nevertheless, in the

broader health insurance market, HMOs compete with other plans, including fee-for-service or preferred provider organizations (PPOs). Dr. Ford has provided no evidence that to the extent that the defendants are making false claims about their HMO plans, purveyors of these other plans would not be motivated to sue under the Lanham Act.

The fourth factor, the speculative nature of the plaintiff's damages, is neutral at best for Dr. Ford. As the district court noted, Dr. Ford dropped his damages claim after class certification was denied, but reserved it in the event that the district court's decision was reversed. In his brief on appeal, he concedes that quantifying any damages would be a complex task. Dr. Ford argues, however, that if only injunctive relief is at issue, this factor actually argues in favor of standing. He relies on the Lanham Act doctrine that a plaintiff's inability to definitively quantify his damages should not preclude the granting of injunctive relief, as an injunction against false advertising benefits the public without causing an undeserved windfall for the plaintiff. *See Am. Council of Certified Podiatric Physicians & Surgeons v. Am. Bd. Of Podiatric Surgery, Inc., 185 F.3d 606, 618 (6th Cir. 1999).* This confuses the issue under the test for prudential standing, which "is to determine whether the plaintiff is 'a *proper* party to invoke judicial resolution of the dispute and the exercise of the court's remedial powers.'" *Conte, 165 F.3d at 225* (emphasis added) (quoting *Bender v. Williamsport Area Sch. Dist., 475 U.S. 534, 546 n.8, 89 L. Ed. 2d 501, 106 S. Ct. 1326 (1986)).* In other words, our focus in resolving Lanham Act standing issues is not whether the uncertain calculation of damages precludes injunctive relief at all, but whether *this particular plaintiff* should be allowed vindicate the public interest. *See Joint Stock, 266 F.3d at 184* (holding that plaintiffs may not circumvent the requirements for prudential

standing by relying on forms of relief that benefit the public at large). Accepting Dr. Ford's argument would essentially render this factor meaningless in every case where injunctive relief is sought, as any plaintiff would be able to cast himself as the "vicarious avenger of the general public's right to be protected against potentially false advertisements." *Id.* (internal quotations omitted).

Perhaps the strongest reason for denying prudential standing is the fifth factor's concern about "the risk of duplicative damages or the complexity of apportioning damages." *Id.* Dr. Ford is but one of innumerable physicians who have contracted with the HMOs, and who therefore have probably lowered fees as a result of the HMOs' bargaining power. If the HMOs' ads were determined to be false, all of these physicians would have damages claims. Moreover, as Dr. Ford concedes, the calculation of these damages would be extremely complex. Finally, doctors are not even the most direct victims of any allegedly false ads, which harm rival health plans more than contracting physicians. In light of the complex and duplicative nature of such damages awards, the fifth factor militates strongly against prudential standing.

To summarize, Dr. Ford has suffered a commercial harm, but his injury is simply not the competitive harm that is protected by the Lanham Act. Of the five factors that are relevant to this analysis, none counsels in favor of prudential standing. Furthermore, there is nothing unfair or premature about resolving this case on prudential standing grounds and applying the more rigorous summary judgment standard, as Dr. Ford was fully aware of his burden to adduce evidence in support of each element of prudential standing. Because I cannot say that he had a sufficient opportunity to address the majority's concerns about constitutional standing, I respectfully concur in the result only.

Footnotes

n1 In his special concurrence, Judge Benavides contends that this case should be decided on the basis of Lanham Act prudential standing rather than Articie III constitutional standing, because the parties did not have an opportunity to brief the latter. This issue ignores the fundamental point that [HN3] wherever possible, Article III standing must be addressed before all other issues "because it determines the court's fundamental power even to hear the suit." *Rivera v. Wyeth-Ayerst Labs., 283 F.3d 315,319.* In the ab sence of Article III standing, we have no right to opine on issues of prudential standing.

The Third Circuit has explicitly recognized that [HN4] Lanham Act prudential standing cannot be addressed so long as Article III standing remains in doubt, because "constitutional standing is a threshold issue that we should address before examining issues of prudential standing." *Joint Stock Soc'y v. UDV N. Am., Inc., 266 F.3d 164, 175 (3d Cir. 2001).* Although the special concurrence attempts to distinguish *Joint Stock* on its facts, the Third Circuit did not rest its holding—that Article III standing should be addressed first—on the specifics of the case before it, but instead adopted this principle as a broad general rule. We see no reason to create a circuit split on this issue.

Even if we did have the authority to forego consideration of Article III standing, there would be no need to exercise it. As the special concurrence recognizes, "to the extent that identical issues have already been raised in the litigation, the threat of procedural prejudice is greatly diminished." In this litigation, the issue of causation that is central to our holding on Article III standing was extensively contested as part of the ongoing dispute over Lanham Act prudential standing.

[HN5] In any inquiry into Lanham Act prudential standing, the court must weigh "(1) the nature of the plaintiff's alleged injury: Is the injury of a type that Congress sought to redress in providing a private remedy for violations of the [Lanham Act]?; (2) the directness or indirectness of the asserted injury; (3) the proximity or remoteness of the party to the alleged injurious conduct; (4) the speculativeness of the damages claim; and (5) the risk of duplicative damages or complexity in apportioning damages." *Procter & Gamble, 242 F.3d at 562.* Causation is undeniably relevant to at least the second, third, and fourth prongs of this test, and defendants have consistently argued that Ford lacked prudential standing in part because he failed to provide adequate evidence of causation.

Despite this repeated challenge, Ford has not provided evidence demonstrating that he has suffered even a small loss as a result of defendants' advertising. He therefore has failed to meet his burden to "set forth by affidavit or other evidence specific facts" validating his right to standing. *Lujan v. Defenders of Wildlife, 504 U.S. 555, 561* (citations omitted).

N2 As we noted in *Rivera*, "there is a limited ex ception for suits in which the class certification issues are "'logically antecedent to the existence of any Article III issues.'" *Rivera, 283 F.3d at 319 n.6* (quoting *Amchem Prods., Inc. v. Windsor, 521 U.S. 591, 612, 138 L. Ed. 2d 689, 117 S. Ct. 2231 (1997)); see also Ortiz v. Fibreboard Corp., 527 U.S. 815, 831, 144 L. Ed. 2d 715, 119 S. Ct. 2295 (1999)* (same). This exception does not apply here, however, for the same reason it was inapplicable in *Rivera*: "In the instant case, in contrast to *Ortiz* and *Amchem*, the standing question would exist whether [the plaintiff] filed his claim alone or as part of a class; class certification did

not create the jurisdictional issue." *Rivera, 283 F.3d at 319 n.6.*

n3 *Cf. Joint Stock Soc'y, 266 F.3d at 175* (holding that Article III "constitutional standing" must be addressed before considering Lanham Act "prudential standing").

N4 *See Joint Stock Soc'y, 266 F.3d at 178* (holding that [HN9] Article III standing for a Lanham Act false advertising claim is lacking where the plaintiff's injuries cannot be traced to the defendants' challenged advertisements "but are rather the result of an independent cause").

N5 *See Johnson v. Bd. Of Regents of the Univ. of Ga., 263 F.3d 1234, 1268 (11th Cir. 2001)* (holding that [HN10] "a plaintiff cannot serve as a class representative if she lacks standing to advance the class's claim").

(Appendix F)

No. 01-20610, Consolidated with No 01-21255

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

KENNETH FORD, DR,
Plaintiff - Appellant

v.

NYLCARE HEALTH PLANS OF THE
GULF COAST INC; ET AL,
Defendants;

AETNA US HEALTHCARE INC, a Texas corporation;
THE METRAHEALTH CARE PLAN OF TEXAS INC;
THE METRAHEALTH INSURANCE COMPANY;
UNITED HEALTHCARE INSURANCE COMPANY INC;
AETNA US HEALTHCARE INC,
a Pennsylvania Corporation,
Defendants - Appellees

August 27, 2002, Filed

JUDGES:

Before SMITH, BENAVIDES, and PARKER, Circuit Judges.

OPINION BY:

Jerry E. Smith

OPINION:

ON PETITION FOR REHEARING AND REHEARING EN BANC

Before SMITH, BENAVIDES, and PARKER, Circuit Judges.

PER CURIAM:

The Petition for Rehearing is DENIED and no member of this panel nor judge in regular active service of the court having requested that the court be polled on Rehearing En Banc (Fed. R. App. P. and 5th Cir. R. 35), the Petition for Rehearing En Banc is also DENIED.

ENTERED FOR THE COURT

Jerry E. Smith

United States Court Judge

Judges King and Jones did not participate in the consideration of the rehearing en banc.